

Perspectives on empathy in patient-GP communication

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Colophon

F. A. W. M. Derksen, 2017

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1

Preface



“I have scant enough advice to give. I would say that you should always remember that the object of your attention is a person. Not an organ, not a procedure, but a real person who suffers; that you always ask who that person is, and how he suffers.”

From: Advice to a Young Doctor, F. Platt, Dec. 2010

This study is about empathy in patient-GP communication. Grounded in daily general practice (GP practice), it represents stories, experiences and opinions of both patients and general practitioners (GPs). Although doctor-patient communication has fascinated me from the moment I started studying medicine, it was not until the end of my GP-career that I decided to conduct scientific research into and to write a thesis on empathy in patient-GP communication. Why did it take so long? First and foremost, I needed to experience and learn from, often surprising, observations with regard to patient-GP communication in general and empathy in daily general practice in particular. Increasingly, over the years, these mostly positive personal experiences became more and more important to me, shaping my own interpretation of being a GP. Secondly, I needed to reflect on the influences of current developments in primary health care on patient-GP communication. Some of the developments I am referring to are: classifying patients into categories of disease, resulting in an increased use of guidelines and protocols; the ascendancy of IT-technology, which, although remarkable and helpful in some ways, can result in the objectification of persons (first the template is checked and only then does the listening to the patient begin); not paying enough attention to patients' expectations of care in GP practice, whereas it are only patients who can determine accurately whether a GP's care has been satisfactory and respectful; and, finally, the ever-increasing power of health insurance companies in the shape of financial regulations and a growing emphasis on quality indicators. It should not come as a surprise that these developments can lead to medicalisation ordinary human problems, and to paying less attention to the central position of the patient and to human-to-human contact in patient-GP communication.

During my 35 years as a GP, I have observed the effects and the importance of building an interested, affectionate and trustful relationship with patients. I have experienced that *listening* is at the core of good and effective communication. In daily GP practice I realized that this listening is only possible when you are curious about the patient's situation and when you are respectfully and genuinely interested in the other person. Being thus attentive and open to learning about the dimensions and complexities of a patient's problem, allows one to better understand the patient's stories. Little by little, using both verbal techniques (such as paraphrasing), and non-verbal techniques (such as eye contact), I developed my consultation and communication skills in daily practice. Simple remarks or questions during the consultation such as *"How are you?"* or *"Can you tell me a bit more about that?"*, or *"Gosh, that must be difficult for you"* or *"Is this how it feels to you?"* , encourage patients to share their experiences and emotions. I have often been surprised by the results of such communication. It allowed me to gain more narrative and useful knowledge of the patient's situation and to better understand the patient's emotions. Patients

seemed to appreciate these consultations and my own job-satisfaction increased. Sharing experiences with colleagues and additional training helped me to further develop these techniques.

In the final years of my GP-career I realized that most of the above-mentioned characteristics of my communication and consultation behaviour were related to the concept of empathy. Although this concept was taught during my first years at medical school, it took me many years to become fully aware of its practical use and role in daily general practice. In my opinion, empathy is one of the most intense aspects of general practice. Putting yourself into someone else's shoes is a difficult, demanding and profound process. How can you begin to understand what it feels like to have an untreatable form of lung cancer? What it feels like to be in an unhappy marriage? What it feels like to have spent years in a concentration camp in your youth? No matter how difficult this can be, it is my experience that it is worth it, because empathic communication in general practice has beneficial results for both the patient and the GP.

Talking with patients, colleagues and nurses over the years, during my career and since retiring, I became aware of problematic situations caused by a lack of empathic behaviour on the part of many caregivers. This made me wonder whether GPs, including myself, other caregivers, and patients have a clear view of the concept of empathy and its role in patient-GP communication. This led to other questions, such as: is there enough knowledge of appropriate empathic skills; can empathy be taught or is it an innate quality; is empathy something that is given only by a GP, or does the patient play a part in it as well; can a GP apply empathy without losing his or her sense of self; does emotional involvement influence a GP's professional objectivity; can we become more empathic over the years; is empathy always positive and useful, or are there pitfalls too?

It is the combination of all the above-mentioned factors – my personal experiences of empathy as a powerful and useful part of patient-GP communication, my questions about several aspects of the concept of empathy, my conviction that empathy should be the foundation of all patient-GP interactions, and my concern about the influence of recent developments in primary health care on empathy in patient-GP communication – that inspired me to explore empathy in this study. I am aware that my personal experiences from daily general practice will have played a part in this undertaking, but I am confident that I have been able to develop an objective researcher's attitude during my research, and I look forward to contribute to general practice with the results of this study.

2

General introduction



***“It is wonderful to notice that you are being
listened to; in daily life, but especially when
visiting your GP. ”***

(a patient)

Introduction

The word empathy is derived from the ancient Greek word *empathia* (εμπάθεια), which in its turn comes from 'em' (into) and 'patheia' (feeling, suffering). The word was introduced into the English language over a hundred years ago, and is a translation of the German term *Einfühlung*, which was introduced by the German philosopher Robert Vischer¹ and adopted by, among others, Theodor Lipps, in their 19th-century writings on aesthetics². The British psychologist Edward Titchener coined the term 'empathy' in 1909³. *Einfühlung* was thought to result from a process where observers project themselves into the objects they perceive. Lipps first put forth a mechanistic account of *Einfühlung*, where the perception of an emotional gesture in another person directly activates the same emotion in the perceiver, without the intervention of any associative or cognitive processes. He linked our recognition of how other people feel directly to our aesthetic appreciation of the beauty of external objects.

"The observer sees a mountain...As his gaze moves upward to the peak of the mountain, his own neck muscles tense and for the moment there is a sensation of rising"^{2,4}.

When a patient visits their general practitioner (GP), a conversation ensues. A story - a state of affairs or a set of events - is recounted by the patient. An illness or a complaint is expressed in words, gestures and body language. Besides giving objective information, the patient expresses their fears and hopes regarding the illness or complaint and talks about how the illness or complaint influences their circumstances. Listening to the patient, the GP follows the story, imagines the situation, recognizes the events described, enters into and is moved by the patient's world. The listener, in developing a picture of the patient's world, is influenced by his or her own diagnostic acts and knowledge as well as memories, associations, interpretations and allusions to stories from this or other tellers. It is by putting oneself in the other's shoes, combined with detailed knowledge of the patient's context, that the GP, together with the patient, is able to find appropriate answers to the patient's questions, which is one of the steps in taking shared decisions^{5,6}.

What is described above is an interpretation of an ordinary patient-GP encounter. Speaking generally, there are two ways in which GPs can help a patient. On the one hand, there can be opportunities to *cure* a patient's *disease* with diagnostic equipment and therapeutic suggestions; on the other hand there can be opportunities to *care* about a patient's *illness* or suffering⁷. It can be supposed that both these characteristics of patient-GP encounters, *cure and care*, can be helped by a GP's style of communication. The narrative characteristic of general practice – the longstanding relationship between patient and GP means that the GP

knows a lot about the patient's current and past situation^{8,9} - and the empathic behaviour of the GP¹⁰ can be considered to be core components of this communication style.

Several theorists and studies have highlighted the effectiveness of empathy within patient-physician communication and the importance of empathy in achieving a satisfying patient-physician relationship^{5,9-13}.

This thesis will focus on empathy in patient-GP communication in daily general practice. GPs' and patients' experiences with empathy and their perspectives on empathy in the clinical encounter will be investigated. In the introduction of this thesis both the concept and the physiology of empathy are described. Furthermore, it depicts relevant changes in primary health care, as well as the gaps in primary care research concerning patient-GP communication in general and empathy in patient-GP communication in particular. Finally, the aims of this thesis are outlined in this introduction.

The concept of empathy

In order to discuss the role of empathy in patient-GP communication it is necessary to try to understand the concept of empathy. There is as yet no clear and complete definition of the concept of empathy, either in general or when speaking specifically about patient-GP communication; there is an ongoing debate about the precise meaning and definition of empathy.

Of course, empathy plays a part in all sorts of situations in which human beings interact; not just in patient-GP encounters. Generally speaking, one can say that empathy is fundamental in interpersonal understanding, relationships and social changes¹⁴. Primatologists, in an attempt to devise a functional description of the concept of empathy, have described it as an essential and socially characteristic attitude of primate species and have discussed it as grounded in the phylogenetic evolution of these species^{15,16}. In recent years behavioural scientists have become more and more interested in investigating the role of empathy in the biological and evolutionary foundations of human social behaviour¹⁷⁻¹⁹. Also, people all over the world, scientists and others have increasingly underlined the more social and humane aspects of the concept of empathy^{14,20-24}.

We will now briefly discuss what three important theorists have said about empathy, or about concepts comparable to what we would now describe as empathy^{25,26}.

Firstly, the thoughts of Michel de Montaigne, a French humanistic philosopher (1533-1592). In his *Essais* he is arguably the first scientist who, in discussing moral and philosophical problems, wrote about himself in a psychological manner.

*“Just observing other people’s pain makes me feel pain myself. Hearing someone else’s constant coughing, makes me feel an irritation in my own lungs and throat”.
(Compagnon, Een zomer met Montaigne, 2014)*

Although Montaigne lived in an age of hierarchy, in which seigneurs and servants lived in different worlds, he was interested in the other person per se²⁷⁻³⁰.

Philosophers with more phenomenological, hermeneutical or theological backgrounds have discussed the various processes that humanizing the other involves³¹⁻³⁶. Ricoeur’s (1913-2005) ‘theory of identity’ is particularly instructive. In this theory he focused on being interested in the other and paying attention to the narratives of people as ‘meaning-oriented beings’. He explicates that considering the other as equal to ourselves almost inevitably makes us concerned about the other. Respecting oneself and the other and accepting each other’s imperfections should be moral imperatives which guide our behaviour. Being part of someone else’s story – being involved with the other – is essential and this is facilitated and stimulated by showing interest in personal narratives. According to Ricoeur it is important to ‘train’ one’s imagination, for instance by reading literature, in order to be able to put oneself in someone else’s shoes. Developing self-knowledge is to him an essential side-effect of this process^{5,37,38}.

This idea of looking someone in the eye, giving them a name and recognizing their individuality being essential building blocks of human relationships has been discussed elsewhere as characteristic of empathizing with someone¹⁴.

Thirdly, the influential theorist Carl Rogers (1902-1987), who worked as a psychotherapist. His non-directive, empathy-based communication style has influenced patient-physician communication over many years and in countless ways. In his book *On becoming a person, a therapist’s view of psychotherapy*³⁹ he posed that the therapist who uses empathy accurately perceives the internal frame of reference of another person, along with the emotional components and meanings attached to it ‘as if’ they were the other person, but without ever losing the ‘as if’ condition, since that could lead to over-identification on the therapist’s side. Nevertheless, he also suggested that a temporary form of identification of the therapist with the client is of vital importance to effective psychotherapy. For years Rogers struggled to construct a definitive description of the concept of empathy. In his ‘benchmark’ definition from the year 1975 aspects such as having no prejudices and the use of emotions are emphasized;

“It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive moment to moment to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or

*confusion or whatever that he/she is experiencing. It means temporarily living in his/her life, moving about in it dedicatedly without making judgments, sensing meaning of which he/she is scarcely aware, but not trying to uncover feelings of which the person is totally unaware, since this would be too threatening. It includes communicating your sensing of his/her world as you look with fresh and unfrightened eyes at elements of which the individual is fearful*⁴⁰ (Van Strien, referring to Rogers)⁴⁰.

Rogers considered empathy to be one of the most potent factors in bringing about therapeutic change and learning. By putting forward specific empathic skills such as reflecting, mirroring and concentrating on non-verbal expressions of the client, he drew attention to the process of the therapeutic setting³⁹.

Within medical academic literature Mercer and Reynolds (in 2002) have formulated a widely accepted definition of the concept of empathy:

*"Empathy is a complex, multi-dimensional concept that has moral, cognitive, emotive and behavioural components. Clinical empathy involves an ability to: (a) understand the patient's situation, perspective, and feelings (and their attached meanings); (b) to communicate that understanding and check its accuracy; and (c) to act on that understanding with the patient in a helpful (therapeutic) way"*⁴¹.

Empathy requires partial identification in order to get a sample of the other individual's experience, but one should be wary of over-identification; an empathic approach does not mean that the physician should take over the problem from the patient^{41,42}.

Summing up, and taking into account other studies on empathy in hospital and GP settings, one can say that the concept of empathy entails affective, cognitive and behavioural aspects^{10,11,43-47}. The *affective* aspect can be described as 'an individual's vicarious emotional response to perceived emotional experiences of others'. It can be seen as a reflection of an innate emotional response, i.e. 'a gut reaction'; in overwhelming situations it can result in sympathy and emotional contagion. The *cognitive* aspect is 'an individual's ability to imaginatively take the role of another so as to understand and accurately predict that person's thoughts, feelings and actions'. This aspect can be considered to refer to the 'perspective taking' aspect of empathy (to have strategies that enable one to take the perspectives of others) and to be based upon a learned ability to imagine and intellectualize (or 'role-play')^{48,49}. The *behavioural* aspect includes various verbal and non-verbal skills^{13,44,46,50} that enable one to recognize the emotional state or situation of the patient, to

be moved by it, to develop a degree of identification with the patient's feelings (e.g. anger, grief or disappointment) and to be able to show this to the patient^{10,51}.

Neural and physiological perspectives on empathy⁵²

Neuroscientists have shown that the capacity for understanding other people's emotions and experiences is hardwired in the human brain through neural pathways activated by direct experience or by observing others^{53,54}.

The discovery of mirror neurons is probably one of the main reasons why empathy is so widely discussed today. During experiments on macaque monkeys during the 1980s and 1990s, Italian researchers (V. Gallese, G. Rizzolatti, L. Fogassi et al.) discovered, more or less by chance, the activity of mirror neurons in the monkeys' brains. They found that mirror neurons connect the observation of an action to the motor program of the same action in the monkey's brains⁵⁵. Since then, in research on people with brain damage – aided by instruments such as transcranial magnetic stimulation (TMS) and functional Magnetic Resonance Imaging (fMRI), areas involved in action observation and execution have been discovered in human brains^{54 56-58}. These areas help to perceive and to evaluate the actions and feelings of other persons, allowing people to learn by observation⁵⁹⁻⁶³. Higher activity of neurons in specific brain areas is associated with higher empathy scores, as measured using Davis' Interpersonal Reactivity Index^{64,65}.

The different brain areas which contain many mirror neurons have been shown to be connected; this is called the 'Mirror Neuron System (MNS)'⁵⁴. Several areas, such as the inferior parietal lobe (IPL), the frontal operculum (FO) and the inferior frontal gyrus (IFG), are both part of the MNS and of an empathy circuit⁵⁶. Recent research into the difference between affective and cognitive empathy shows that the anterior insula (AI), the anterior and dorsal mid- cingulate cortex, the inferior frontal gyrus (IFG), the amygdala, the periaqueductal gray (PAG), and the secondary somatosensory cortex are the most consistently activated sites in *affective empathy*. Sites activated during *cognitive empathy* include the temporoparietal junction, superior temporal sulcus, dorsomedial PFC, ventromedial PFC, and the posteromedial parietal cortex. In this context, it seems like there is a low road and a high road in human brains, the low road being the affective one (connected to the amygdala) and the high road being the cognitive one^{17,48,61}. A number of imaging studies have demonstrated how the brain is differently activated in these two forms of empathy⁶⁶.

In addition it has been found that these neural circuits are linked to the limbic system by means of an anterior sector of the human insular lobe^{47,57,58}. For example, the cingulate cortex is activated by experiences of touch, somatic sensations, pain and emotions, both one's own and those of other persons⁶⁷. That way, seeing another person's pain results in a response of the observer's motor system (e.g. pulling back one's hand when seeing

someone else cutting their finger)^{62,68}. Some of these areas are also active in processing linguistic items such as metaphors⁶⁹. Recently however, doubt has been cast on the assumption that mirror neurons are responsible for a wide range of abilities such as language acquisition^{67,70}.

One of the reasons we should be careful with claims about mirror neurons is that fMRI images are by no means perfect. Active neurons need more oxygen; fMRI scans are used, with help of different magnetic characteristics, to detect which brain areas are active by measuring the flow of oxygenated and deoxygenated blood. However, there are limits to what a fMRI scan can show, due to the circuitry and functional organization of the brain⁷¹⁻⁷³.

These findings support the idea of a neurophysiological base of empathy. In addition, recent genetics research foster the idea of physical aspects of empathy. Empirical evidence for the genetic influence on the production of hormones (vasopressin and oxytocin) which are involved in empathy has been provided^{56,74-76}. Moreover, research into the possible relationship between empathy and autism spectrum disorders seems to be supported by genetics research. Mutations in genes, identified as risk genes for autism, suggest a causal role for specific gene contributions in the aetiology of autism⁷⁷.

Besides, within the same framework of physical aspects of empathy, our physical response to someone else's experiences can be seen as a cascade of reactions in the autonomic nervous system. The physical signs of emotions are founded in the hypothalamic- pituitary-adrenal axis and in hormonal systems affecting several target organs^{67,78,79}. These physical responses can be observed by measuring skin conductance or SC (the release of sweat from the exocrine glands, which are controlled by the sympathetic nervous system) or heart rate⁶⁷. The significant correlation between changes in SC-levels and patient-perceived empathy suggests and supports the existence of a biological model⁸⁰.

Empathy and changes in priority setting in general practice

Over the last decades many changes have been implemented in order to streamline daily general practice. In addition to the gate-keeping function of general practice, enhancing long-term relationships between patient and GP and a person-centred approach, there has been an increasing focus on the organization of chronic care and evidence-based medicine⁸¹⁻⁸³.

Evidence-based medicine has become a significant factor in general practice, manifesting itself in the development and use of more than a hundred different protocols and guidelines⁸⁴. These guidelines, however, can be experienced by GPs as obstacles and non-compliance is widely reported^{85,86}. Modern general practice has expanded its capacity to diagnose; an efficient and more technology-based approach to the (chronic) disease of the patient seems to have become of vital importance. Partly as a result of these changes, patient-GP communication has shifted from being affect-oriented communication, of which listening and

empathy are central characteristics, towards task-oriented communication⁸⁷. As a result of political decisions, health insurance companies have contributed to this somatically focused development by introducing a pay-for-performance system based on quality indicators⁸⁸.

Concerns about the negative effects of these developments on patient-GP communication have become more and more widely discussed^{51,79,89-91}. At the same time, there has been a growing interest in empathy and the importance of the patient-GP relationship, especially with regard to symptoms that cannot be medically explained^{92,93}.

Over the years, the organization of general practices has changed from individual and small practices with one or two GPs and a practice assistant, towards more group practices with various caregivers delivering integrated and multidisciplinary care, organized around specific chronic diseases such as diabetes and COPD. Research shows that the organization of general practice is one of the important contextual factors which influence the affect-oriented part of GPs' communication styles^{87,94}. So far there has not been much attention to the influence of recent developments in the organization of primary health care on empathy in patient-GP communication⁹⁵. It seems likely that a disease-centered approach and organization can lead to a growing dichotomy between a biomedical or a humane basis of general practice and that it would influence patient-GP communication.

Empathy and changes in patients' expectations

The role and behaviour of patients has also evolved over the years. They are better informed (e.g. due to the internet) and take a more assertive role in the consultation; the patient-GP relationship has become more equal in all aspects⁸⁷.

Generally, patients expect doctors to be trustworthy and to act in the interest of their patients; patients want doctors to be involved with them and expect their medical expertise to go hand in hand with their communication skills⁹⁶. Furthermore, patients expect clinicians to respect their autonomy, to listen to them, to inform them, to take account of their preferences, to involve them in treatment decisions and to support their efforts in self-care⁹⁷. Patients value an individually tailored form of communication with caregivers in which attention is paid to the effects of symptoms or a disease on their lives^{87,89,95,98-101}.

When asked about empathy as a specific part of patient-GP communication patients assess the physician's explicit expressions of empathy and involvement as a key issue in their definitions of quality of care^{11,95,99,102,103}. Patients complain about less empathic physicians^{43,99,104}.

In contradiction to these clear opinions, research shows that patients have not become more prone to asking their health care providers questions over the past decades^{87,95}. Neither do patients tend to fully express their concerns to a physician; rather, they often use 'cues' -

defined as verbal or non-verbal hints which suggest an underlying emotion - to express their worries during the consultation^{87,105-108}.

Gaps in research on empathy in general practice

Scientific research into empathy flourishes, not only in neuroscience, but also in philosophical ethics, psychology, sociology, law, evolutionary theory, psychoanalysis, artificial intelligence, primatological and biological science^{15,25,109}. There are however relatively few papers that specifically report on the role of empathy in general practice. Patient-GP communication has mainly been a subject within observational studies and theoretical publications^{100,101,110-112}. Affective communication in particular was found to be important in predicting patients' feelings of satisfaction and patients' opinions on the quality of health care^{100,113}. Recent research has been focused on educational aspects of patient-GP communication¹¹⁴⁻¹¹⁷, and the effects of different contextual factors on patient-GP communication have been charted as well^{94,118}.

There have been studies of how patients assess communication in general practice^{99,119}. Patients' stories have been recounted in books and blogs^{120,121}. It is clear that in Western European countries an empathic and genuinely interested approach by physicians is generally highly valued^{99,122,123}. In addition, Vedsted et al. found that patients tend to recommend their GP to others if they judge them to be empathic¹²⁴. Verheul et al. investigated the impact of a warm and empathic consultation as opposed to a cold and formal consultation; it showed that the greatest beneficial effects of empathic communication were on stress reduction¹²⁵.

Research within general practice – involving only patients with medically unexplained symptoms and palliative patients - shows that patient-centered communication, consisting of supporting and empathetic behaviour and a trustful relationship, is associated with better patient outcomes and patient satisfaction^{126,127}. The use of guidelines, carefully investigating the physical complaint, combined with empathic behaviour was shown in studies with refugees to deliver the most effective care^{128,129}.

On the other hand, a study focusing on GPs' empathic behaviours, based on observational research of video-taped patient-GP consultations, shows that there has been a decrease in applying empathy and compassion in GP practice over the last decade⁸⁷. In a critical review, investigating the decreasing use of empathy in the consulting room, Pedersen suggested that physicians, working within the framework of a predominantly biomedical approach and as a result of the medico-scientific education of physicians, separate biomedical aspects from human experience. According to him, empathy is often considered by physicians to be a time-consuming and non-effective characteristic of the patient-GP encounter¹³⁰.

Looking at previous research, there is as yet little knowledge of the personal experiences of patients and GPs with regard to various aspects of patient-GP communication. Additionally, we were not able to find previous papers or conclusive general practice research which paid attention to the personal experiences and views of GPs and patients regarding the role and influence of empathy in general practice. Neither have we been able to find previous research into patients' and GPs' opinions and expectations about how recent contextual developments in general practice have influenced (positively or negatively) the position of empathy in their communication. Research in this field is all the more important because restoring the human dimension in primary health care should be grounded on fieldwork with patients.

Concerning GPs, there is only limited insight into their knowledge of empirical research about the effectiveness of empathy in general practice.

Much can be learned from experiences and views of patients and health care providers who deal with either the presence or the lack of empathy in patient-GP communication. Since not much is known about this topic, we believe that a study into patients' and GPs' perspectives on empathy in patient-GP communication was called for and that qualitative research is ideally suited to explore the issue. Qualitative research allows us to observe experiences with and opinions on empathic behaviour, as well as views on empathy in relation to current developments in primary health care. We hope that a clearer picture of the subject will produce suggestions to improve the implementation of empathy in general practice and, as a result, to more satisfied patients and GPs.

Aims of this study

To address the gaps in existing knowledge about the implementation of empathy in GP practice, several research objectives were formulated:

- To describe the existing knowledge of scientific studies which investigated the proven effectiveness of empathy in general practice.
- To specify and to compare where and how patients and GPs may have differing expectations and opinions with regard to empathy in patient-GP communication.

Pertaining only to patients:

- To describe patients' experiences with and opinions about empathy during consultations in primary care, and how they value it.

Pertaining only to General Practitioners:

- To describe GPs' experiences with and opinions about empathy and to explore obstructing and facilitating factors in the implementation of empathy in daily general practice.

Outline

The results of the objectives that were formulated will be described in the following chapters of this thesis.

Chapter three presents the results of a review of literature about studies which investigated the proven effectiveness of empathy in patient-GP communication.

Chapter four describes the results of a focus group study with patients about patients' experiences, views and expectations regarding empathy.

Chapter five reports the findings of individual GP-interviews. This chapter focuses on the exploration of GP's experiences with empathy and how they apply empathy in daily practice; it reports the investigation of the use of empathy in actual practice and of GPs' views on which factors enable or facilitate the use of empathy.

Chapter six also reports the findings of individual GP-interviews and focuses on GPs' views on the barriers they experience in behaving empathically and how they deal with these barriers.

Chapter seven evaluates the gap that both patients and GPs can experience between wish and reality in receiving and offering empathy.

Chapter eight discusses and integrates the findings of the preceding chapters and describes how these findings relate to existing literature. It also deals with the methodological strengths and limitations of this thesis and its implications for further research, organization of general practice and vocational GP education.

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3

The effectiveness of empathy in general practice; a systematic review.

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***“Empathy enables mutual openness and good insight. That improves the chances of a good diagnosis, I would say”
(a patient).***

“When you apply empathy, you can get to the central issue much more quickly, and once you know what the issue is, you get a sort of domino effect. You can put things into words, answer questions, look at different options together, and develop a plan of treatment.”

(a GP)

ABSTRACT

Background

Empathy as a characteristic of patient-physician communication in both general practice and clinical care is considered to be the backbone of the patient-physician relationship. Although the value of empathy is seldom debated, its effectiveness in general practice is little discussed. This literature review explores the effectiveness of empathy in general practice. Effects that are discussed are: patient satisfaction and adherence, feelings of anxiety and stress, patient enablement, diagnostics related to information exchange and clinical outcomes.

Aim

To review the existing literature concerning all studies published in the last 15 years on the effectiveness of physician empathy in general practice.

Design

Systematic literature search

Method

Searches of PubMed, EMBASE and PsychINFO databases were undertaken, with citation searches of key studies and papers. Original studies published in English written between July 1995 and July 2011, containing empirical data about patient experience of GPs' empathy were included. Qualitative assessment was applied using Giacomini and Cook's criteria.

Results

After screening the literature using specified selection criteria 964 original studies were selected, of these seven were included in this review after applying quality assessment. There is a large correlation between physician empathy and patient satisfaction and a direct positive relationship with strengthening patient enablement. Empathy lowers patients' anxiety and distress and a relationship with better clinical outcomes seems to exist.

Conclusion

Although only a small number of studies could be used in this search, the general outcome seems to be that empathy in the patient-physician communication in general practice is of unquestionable importance.

Keywords

empathy; general practice; general practitioner

Introduction

Patients consider empathy as a basic component of all therapeutic relationships and a key factor in their definitions of quality of care^{1,2}. A hundred years ago Titchener introduced the word 'empathy' into the English literature, based on the philosophical aesthetics concept of 'Einfühlung' of Theodor Lipps³. Another important historical moment is the way Rogers speaks about empathy in 1961 in his book: *On Becoming a Person; a Therapist's view of Psychotherapy*⁴. Since then, various authors have written about empathy in the setting of psychotherapy and about its functionality in patient-physician communication. Neuroscientific research of recent decades has achieved significant progress in establishing the neurobiological base for empathy after discovering the MNS (Mirror Neuron System)^{5,6} as probably being related to people's capacity to be empathic⁷. Scientists have now added new insights, based on functional magnetic resonance imaging (fMRI) experiments. They have discovered that the MNS consists of the mirror neurons in the ventral premotor cortex and the parietal area of the brain and neurons in the somatosensory areas and in limbic and paralimbic structures⁸. The insula plays a fundamental role in connecting these regions⁹.

fMRI experiments have shown that individuals who score higher in a questionnaire measuring their tendency to place themselves in the other person's shoes, activate their MNS more strongly while listening to other people's problems^{10,11}. These results draw the 'soft' concept of empathy into 'hard' science, which opens a challenging new field of research with potentially important clinical implications¹². However, these neurobiological studies do not give information about the impact of empathy in clinical care. Within the current opinion of 'evidence based health care' it is important also to get evidence about the effectiveness of empathy in the daily practice of GPs.

To assess the effectiveness of empathy, it is necessary to define what authors mean when using the term 'empathy'. Although many authors experience difficulties in giving a clear definition^{1,2,13-20}, a number of core elements can be identified.

In general, authors consider empathy as the competence of a physician to understand the patient's situation, perspective and feelings; to communicate that understanding and check its accuracy; and to act on that understanding in a helpful therapeutic way. It has an affective, a cognitive and a behavioural dimension^{1,21-24}.

Empathy can therefore be defined at three levels: as an **attitude** (affective)^{25,26} as a **competency** (cognitive)^{2,15} and as a **behaviour**^{2,16}.

Attitude is based on moral standards in the mind of the physician; such as respectfulness for the authenticity of the other person, interest in the other person, impartiality and receptivity. These standards are formed by a physician's own human development, their socialisation process, their medical training, their personal experience with patients, by reading professional literature and by watching movies and reading books^{13,15,22,27-29}.

Competency can be subdivided in an empathic skill, a communication skill and the skill to build up a relationship with a patient based on mutual trust. Empathic skill is the approach by which the physician can elicit the inner world of the patient and get as much information as possible from the patient, while at the same time recognizing the patient's problem^{2,30,31}. Communication skill is used to check, clarify, support, understand, reconstruct and reflect on the perception of a patient's thoughts and feelings^{15,23}. The skill to build up a trustful and long-standing patient-physician relationship encourages physicians to resonate with the patient emotionally. These long-term relationships are important for telling and listening to the stories of illness^{32,33}.

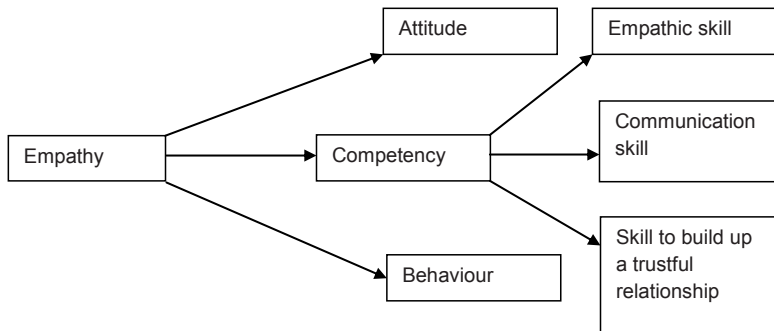
Behaviour has a cognitive and an affective part. The cognitive part includes verbal and/or non-verbal skills^{14,15,22,25,26}. The affective part includes recognition of the emotional state or situation of the patient, being moved, and recognizing a feeling of identification with someone who suffers with anger, grief and disappointment. After this recognition the physician, in their behaviour, reflects on and communicates their understanding to the patient (Figure 1)^{20,23}. Both patients and physicians, mention empathy as the basis for a humane patient-centred method in general practice and as an important component of professionalism^{1,17,34}. A large number of patients, nearly 80%, would recommend an empathic physician to other individuals³⁵.

Despite these opinions, one can see a decrease of interest in good patient-physician communication. Reynolds et al. report a low level of empathy in professional relationships³⁴. In their view this is widespread in modern medicine and many recipients of professional help may not feel that their situation is understood by professionals³⁴. A study by Kenny et al. suggests that physicians and patients have a different perspective on physicians' communication skills: the perceptions of the medical encounter have been characterized as being so different that they appear to be from 'different worlds'³⁶.

Moreover, different authors report a rising prevalence in the last decade of technological and biomedical aspects of care and of more emphasis on effectiveness and productivity in family care^{17,20,37}. Peabody proved to be prophetic when, in 1927, in his lecture '*The Care of the Patient*' he expressed concern that rapidly growing scientific technology was crowding out human values in the management of patients³⁸. Just as Spiro asks attention for the 'unseen and unheard' patient in these developments²⁰ it is important to pay attention to the effectiveness of empathy in the patient-physician communication.

The purpose of this literature review is to get a clear view on the proven effectiveness of empathy in patient-physician communication, in particular in general practice.

Figure 1. Subdivisions of empathy.



Method

A search was undertaken of PubMed, EMBASE and PsychINFO databases between July 1995 and July 2011, with the support of a professional librarian, to identify studies of general practice, empathy and effectiveness or outcome of empathy. As Beck et al. stated that there is a lack of empirical studies focusing on empathy in general practice before 1995, we decided to start our search at July 1995³⁹.

The search terms used are shown in Box 1. The search was performed using major medical subject heading (MeSH) terms in titles and/or abstracts (See Box 1). After removal of duplicate studies, titles and abstracts were assessed by the first author (FD) as to whether the articles were pertinent to this literature review and whether they dealt with general practice. Potentially relevant articles were read in full text. Further papers were sought by checking references and citation searches of included and other leading articles (snowball method). After this selection, articles were assessed whether or not they fitted within the inclusion criteria. This was done by the first author (FD) and discussed with the other members of the research team (AL and JB).

To fulfil the inclusion criteria, articles had to detail original and empirical studies, published in English. Studies had to contain patients' experiences, and outcome measures of empathy and measures of GPs' empathy. Exclusion criteria were: reviews, guidelines and theoretical or opinion articles. In order to be included in this review, during the final selection, the studies had to fulfill all four criteria of quality developed by Giacomini and Cook (40) (Box 2). From the initial 964 papers, seven meeting the inclusion and qualitative criteria were identified (Figure 2).

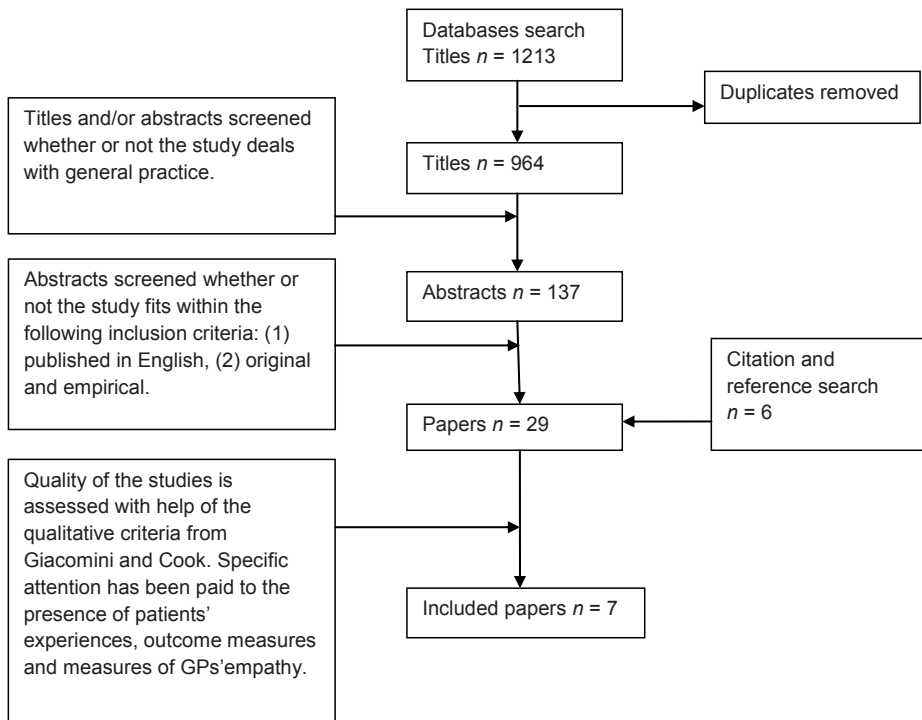
Box 1. Database search terms used.

((empathy[Mesh] OR empath*[tiab])) AND (Physicians, Family[MeSH] OR Primary Health Care[MeSH] OR Family Practice[MeSH] OR "General Practice"[Mesh] OR "General Practitioners"[Mesh] OR Family Physician*[tiab] OR Primary Health Care[tiab] OR Primary Healthcare[tiab] OR Primary Care[tiab] OR Family Practice*[tiab] OR General Practice*[tiab] OR General Practitioner*[tiab] OR Family Medicine[tiab]) AND outcome*[tw]

Box 2. Giacomini and Cook's criteria.

1. The participant selection is well reasoned and the inclusion is relevant to the research question; the population is representative.
2. The data collection methods are appropriate for the research objectives and setting; the data collection is valid and reliable.
3. The data collection process, which includes field observation, interviews, and document analysis, must be comprehensive enough to support rich and robust description of the observed events.
4. The data must be appropriately analysed and the findings adequately corroborated by using multiple sources of information.

Figure 2. Selection process for papers on the effectiveness of empathy in General Practice



Results

Seven studies were found (Table 1)⁴¹⁻⁴⁷. The effectiveness of empathy in patient-physician communication in the studies included is described as possible relationships between empathy and improvement of patient satisfaction and adherence, decrease of anxiety and distress, better diagnostic and clinical outcomes, and more patient enablement. Patient outcomes were measured by questionnaires, laboratory tests and by analysing interviews and video-tapes.

Improvement of patient satisfaction and adherence

Hojat et al. found a large correlation between patients' satisfaction and their perceptions of physicians' empathic engagement⁴¹. Corrected item-total score correlations of the patient satisfaction scale ranged from 0.85 to 0.96; correlation between patient satisfaction scores and patient perception of physician empathy was 0.93⁴¹.

Decrease of anxiety and distress

In the study by van Dulmen et al. it was found that the more anxious patients were, the more adequate their GPs tended to respond. Patients who perceived their GP as empathic reported lower levels of anxiety⁴².

Better diagnostics and clinical outcomes

Levinson and Roter confirm that communication between physicians and patients is associated with underlying physician attitudes⁴³. Specifically, physicians with positive attitudes towards psychosocial issues make more statements expressing concern and empathy. The patients of these physicians offer relatively more information about psychological and social issues. These patterns of communication are associated with improved patient satisfaction and patient outcomes⁴³. An underlying attitude of genuine interest and empathy, within a continuing relationship, was highly valued. Patients described how the GP's attitude helped or hindered them in discussing their problems. Patients also described how the GP helped them make sense of, or resolve their problems, and supported their efforts to change⁴⁴.

Hojat et al. found a positive relationship between physician empathy and patients' clinical outcomes. Patients with diabetes had their glycosylated haemoglobin (HbA1c) and low-density lipoprotein (LDL) cholesterol tests checked. Both tests showed significantly better results in patients with a more empathic physician. It is suggested that more empathy in the physician-patient relationship enhances mutual understanding and trust between physician and patient, which in turn promotes sharing without concealment, leading to a better alignment between patients' needs and treatment plans and thus more accurate diagnosis and greater adherence⁴⁵.

Table 1: Summary of included articles

Author	Country	Measure/ empathy level	Design/Method	Sample size	Research Question	Key findings
Hojat et al. 2011 ⁴⁵	US	JSPE/ physician rating/ cognitive	Correlational study/ laboratory data	891 patients/ 29 GPs	To test the hypothesis that physician empathy is associated with positive clinical outcomes for patients with diabetes.	Patients of physicians with high empathy scores were significantly more likely to have good control of HbA1c (56%) than were patients of physicians with low empathy scores (40%). Similarly, the proportion of patients with good LDL-C control was significantly higher for physicians with high empathy scores (59%) than for patients of physicians with low scores (44%).
Rakel et al. 2011 ⁴⁶	US	CARE/patient rating/skill, attitude	RCT/ questionnaire, laboratory results	719 patients/ 6 GPs	To evaluate the effects of patient- physician interaction on the severity and duration of the common cold	The 'physician empathy perfect' group was associated with the shortest cold duration (5,89 days versus 7,00 days). The amount of change of interleukine-8 and neutrophil level was greater for the 'physician empathy perfect' group.
Van Dulmen et al, 2004 ⁴²	Nether- lands	RIAS/ observer rating/skills	Patients' questionnaire, analyzing video- consults	698 patients/ 142 GPs	To examine the physician's responses to patients' concerns in relation to the patient's preference and perception and the level of anxiety provoked by the medical visit.	99% of the patients reported that they have perceived their GP to be empathic. The patients who had perceived a more empathic GP reported lower levels of anxiety.

Mercer et al, 2008 ⁴⁷	Scotland	CARE/patient rating/skill attitude PEI (patient enablement instrument)	Questionnaire	136 patients/ 5 GPs	To investigate the relationships between GPs' empathy and patient assessed outcomes in primary care consultations in an area of high socioeconomic deprivation in Scotland.	There is a direct relationship between physician empathy and patient enablement.
Hojat et al, 2011 ⁴¹	US	JSPPE/ patient rating	Development and evaluation of a questionnaire	535 patients	To develop and examine an instrument to measure patients' overall satisfaction with their GP.	A large correlation between the perception of physician empathy and patient satisfaction.
Buszewicz et al, 2006 ⁴⁴	UK	TAR interview/ patient rating	Patients' interviews	20 patients/ 12 GPs	To identify which aspects of GP consultations patients presenting with psychological problems experience as helpful or unhelpful.	Genuine interest and empathy, within a continuing relationship, was highly valued both for psychological and non-psychological problems
Levinson et al, 1995 ⁴³	US	RIAS/ observer rating	Analysing audiotapes and questionnaires	412 patients/ 50 GPs	To assess the relationship between physicians' beliefs about the psychosocial aspects of patient care and their routine communication with patients.	Physicians who had positive attitudes used more statements of emotions, such as empathy, reassurance, and fewer close-ended questions than did their colleagues who had less positive attitudes. The patients of these physicians offer more information about psychological and social issues.

CARE = the Consultation and Relational Empathy measure. HbA1c = glycosylated haemoglobin. JSPE = Jefferson scale of Physician Empathy. JSPPE = Jefferson Scale of Patient Perception of Physician Empathy. LDL-C = low density lipoprotein cholesterol. RCT = randomised controlled trial. RIAS = Roter Interaction Analysis System. TAR = Tape Assistance Recall method.

Even the most common infectious disease on earth, a common cold, is shown to last for significantly less time and to be less severe in cases where there is good physician-patient empathy. A 'physician empathy perfect group' was associated with the shortest cold duration (5,89 days versus 7,00 days). The amount of change of interleukine-8 and neutrophil level was greater for the 'physician empathy perfect group'. Interleukin-8 and neutrophil counts were obtained from nasal wash at baseline and 48 h later⁴⁶.

More patient enablement

There is a direct positive relationship between GP empathy and patient enablement, as well as between enablement and changes in main complaint and wellbeing⁴⁷. Patient enablement was measured by the Patient Enablement Instrument (PEI) with questions on topics such as: ability to cope with life and illness and patients' confidence about their health and their ability to help themselves⁴⁷.

Discussion

Summary of the main findings

This review investigates the relationship between GP empathy and patient outcomes. A GP's daily practice involves many elements that are not evidence based. The existence and use of empathy in communication is one of these 'soft' elements. However, this review shows that there is a relationship between empathy in patient-physician communication and patient satisfaction and adherence, patients' anxiety and distress, better diagnostic and clinical outcomes and strengthening of patients' enablement.

As mentioned in the introduction, there are different levels of empathy. Authors used different types of tests to measure these different levels, such as the Jefferson Scale of Patient Perceptions of Physician Empathy (JSPPPE), a patient rating system; the Jefferson Scale of Physician Empathy (JSPE) a self-report measuring scale for cognitive and attitude factors; the Consultation and Relational Empathy Measure (CARE), a patient rating system that measures physicians' communication skills and attitudes; the Roter Interaction Analysis System (RIAS), an observer rating system that measures empathy skills and the Tape Assisted Recall method (TAR) which measures the development of a long-working relationship⁴⁸.

Strengths and limitations

The self-imposed limitation to start the literature research from 1995 might have result in studies being missed, however Beck et al. in a previous review stated that actual empirical data about empathy in general practice, before 1995, were relatively scarce³⁹. With the inclusion criteria used in this review, seven articles were found with a bearing on general

practice.

The application of the inclusion and exclusion criteria have been performed by one member of the research team. Although, the results of the study selection was discussed in the research team, this could have led to a reviewer bias. Moreover, the applied Giacomini and Cook criteria are not validated to assess the quality of the included articles; at the most they can deliver some insight in the quality of qualitative research.

This study has a potential cultural bias in interpreting and judging phenomena by standards inherent to European culture. General practice in Europe is most commonly delivered by GPs. In the US primary care includes both general internists and pediatricians, as well as GPs.

A possible limitation of this review is the underexposure of 'the danger of empathy', such as physicians losing their professional distance, which, in certain situations, might make empathy a less desirable aspect of patient-physician communication^{16,49}.

In focusing on empathy, the effects of contextual factors on specific health outcomes are possibly underexposed such as intrinsic/extrinsic factors, health-care setting, access to care, GP's workload or pressure and sociocultural factors⁵⁰. General limitations of this review are that only articles written in English are included. Furthermore, the existing measures of empathy have been taken as presented in the literature; no critical reflection of the validity of these measures has taken place.

Comparison with existing literature

The results of the studies seem to be supported by other authors. For patient satisfaction and adherence, Neumann et al.²¹, Kim et al.⁵¹ and Lelorain et al.⁵² confirm the data; they found links between physician empathy and patient satisfaction, however studying various clinical settings. Mercer et al. have shown that patients view quality of consultation in general practice as related to both the GP's competence and the GP's empathic care⁵³. Further Neumann et al. argue that affective-oriented effects of empathy are related to more satisfaction, adherence and trust¹⁶. Indirectly, patients who are more satisfied with the care received, exercise greater adherence to agreed and recommended treatment regimens and courses of action².

In relation to decrease of anxiety and distress, in experimental research in which a GP was trained in special communication styles, Verheul et al. found that combining a warm and empathic communication style with raising positive expectations leads to positive effects on the patient's anxiety¹².

In relation to better diagnostics and clinical outcomes authors have shown that empathic communication achieves the effect that patients talk more about their symptoms and concerns, enabling the physician to collect more detailed medical and psychosocial information. This leads to more accurate medical and psychosocial perception and ultimately

to more accurate diagnosis and treatment regimens^{13,22}. Neumann et al. based their 'effect model of empathic communication in the clinical encounter' on this evidence¹⁶. It has also been mentioned that patients' overall satisfaction with health care services, adherence with medical regimens, comprehension and perception of a good personal relationship are positively related with interpersonal communication between the patient and care provider and are particularly related to the physician's empathic behaviour^{24,39,50-54}. However, physician-perceived stress has also been shown to correlate negatively with enablement⁵⁵.

Implications for practice and research

Empathy is a familiar term in the helping and caring literature. In 2008 the World Health Organization (WHO) reaffirmed the importance of primary health care with its report '*Primary health care now more than ever*'⁵⁶. The key challenge was 'to put people first, since good care is about people'⁵⁶. Rakel said that good medical care will continue to depend on care by concerned and compassionate family physicians who can communicate with patients, understand them, know their families and see them as more than a case⁵⁷.

Qualitative studies show that physicians link empathy to fidelity, pro-social behaviour, moral thinking, good communication, patient and professional satisfaction, good therapeutic relationships, fewer damage claims, good clinical outcomes and building up a trustful relationship with the patient^{15,24,25,58,59}. In her study, Shapiro explored how primary care clinician-teachers actually attempt to convey empathy to medical students; they argued that the moral development of the GP, their basic willingness to help, their genuine interest in the other and the emphasis on the other's feelings are basic principles for acceptance of the empathic approach of the patient²⁵.

In GPs' views limiting factors during consultation are; time pressure, heavy workload, a cynical view on the effectiveness of empathy and a lack of skill^{13,51,60}. Neumann et al. have shown that patients also see time pressure and busyness on the physician's part as a limiting factor²¹. Thus, empathy can be seen as a part of the patient-GP communication, characterized by feelings such as interest and recognition and the physician remaining objective. However, barriers exist for implementation in general practice^{13,14,24,30,31,48,61,62}.

Another finding of this review is that some studies suggest that the degree of empathy shown by medical students declines over the course of their training^{20,63,64}. Empathy appears to increase during the first year of medical school, but decreases after the third year and remains low through the final year of medical school, measured using the Jefferson Scale of Physician Empathy–Student Version (JSPE- S)^{17,64,65}. In the study by Hojat et al. there are no sex differences. On the other hand Quince et al. discovered that among males during medical education, in both the bachelor and clinical phases, affective empathy slightly but significantly declined and cognitive empathy was unchanged. Among females, neither

affective nor cognitive empathy changed⁶⁶. It is ironic that there are indications that when students can finally begin doing the work they came to medical school to do (that is, taking care of patients) they seem to begin losing empathy⁶⁷. Possible explanations of the decline are: a lack of good role models and changes in general cultural and ethical views on illness, health and portrayals of mankind. Interviews with physicians show that they think that in current Western society, it has become less a part of human nature to be interested in another person and to be affected by someone else's misery¹⁷. In their study of American college students, comparing the temporal change of 1979 and 2009, Konrath et al. showed that this development has social roots⁶⁸. Considering these possible tendencies in education and the above-mentioned technological changes within the health-care system, which probably influence the patient-physician alliance negatively and could undermine empathy in these relationships, it makes sense to emphasize the results of our review. The evidence of a correlation between empathy and clinical outcomes should be made widely known, especially among medical students and physicians. Some authors already believe empathy can be improved by targeted educational activities and they indicate possibilities to enhance empathy during education^{16,17,26,38,67-69}.

It should be mentioned that, until now, the widely acclaimed benefits of empathy only have a small empirical base. Although a few studies of sufficiently high quality show promising results, much more research is needed to claim the effectiveness of empathy in clinical practice on evidence-based grounds. Neumann et al. have already highlighted the need for an examination of the cost-effectiveness of empathy in the light of the recent focus of policymakers and health insurers on the efficiency of health care¹⁶. It is a challenge to draw the attention of policymakers to empathy as an effective and efficient way of delivering health care. A vast majority of patients want empathic physicians, particularly but not exclusively, in general practice⁷⁰. Indirectly, authors suppose empathic behaviour improves the physician-patient relationship and causes satisfaction for the patient but also for the physician^{1,13,22}, resulting in fewer cases of compassion fatigue or burn out.

Further research is needed on the practical use of empathy in general practice, with a focus on the effects and side effects of empathy and the expectations of patients and GPs. In this context, it is important to take account of how researchers have measured empathy. Measuring empathy is often based solely on self-reports and is therefore often remote from patients' and physicians' concrete feelings, experiences and interpretations in practice. Only patient-perceived empathy is significantly related to patient outcomes. Therefore, it appears best to use a patient-perceived empathy scale to measure physician empathy in practice^{39,48,61,63,71}.

It is remarkable that empirical studies on physician empathy are still relatively scarce. According to the results of the studies included in this systematic review, the presence of

empathy can be regarded as possibly related to patient satisfaction and adherence, to decreasing patients' anxiety and distress, to better diagnostic and clinical outcomes and to strengthening patient enablement.

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4

Consequences of the presence and absence of empathy during consultations in primary care; a focus group study with patients.

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“To me, empathy means that my GP really understands me and shows his understanding and compassion. It makes me feel that he is right beside me, that he is walking shoulder to shoulder with me; it makes me confident of his support.”

(a patient)

ABSTRACT

Objective

There is general consensus that explicit expression of empathy in patient-GP communication is highly valued. Yet, little is known so far about patients' personal experiences with and expectations of empathy. Insight into these experiences and expectations can help to achieve more person-centeredness in GP practice care.

Methods

Participants were recruited by a press report in local newspapers. Inclusion criteria: adults, a visit to the GP in the previous year. Exclusion criterion: a formal complaint procedure. Five focus groups were conducted. The discussions were analyzed using constant comparative analysis.

Results

In total 28 participants took part in the focus group interviews. Three themes were identified: (1) Personalized care and enablement when empathy is present; (2) Frustrations when empathy is absent; (3) Potential pitfalls of empathy. Participants indicated that empathy helps to build a more personal relationship and makes them feel welcome and at ease. Furthermore, empathy makes them feel supported and enabled. A lack of empathy can result in avoiding a visit to the GP.

Conclusion

Empathy is perceived as an important attribute of patient-GP communication. Its presence results in feelings of satisfaction, relief and trust. Furthermore, it supports patients, resulting in new coping strategies. A lack of empathy causes feelings of frustration and disappointment and can lead to patients avoiding visiting their GP.

Practice implications

More explicit attention should be given to empathy during medical education in general and during vocational GP-training.

Introduction

Explicit expression of empathy on the GP's part is highly valued by the general public and patients alike¹⁻³. Patients consulting GPs (General Practitioners) with psychological problems in particular regard empathy and the use of empathic statements by GPs as important aspects of a caring attitude^{4,5}. Patients consider empathy to be so important, that recommending a GP to others is strongly associated with the empathic characteristics of that GP⁶. Mercer et al., studying patients' views of the quality of GP consultations, found that the doctor's empathic concern was regarded as one of the core elements of consultations in GP practice⁷. These experiences are all the more interesting because of the mounting evidence that empathy is closely associated with outcomes measures such as lower levels of HbA1c and LDL-cholesterol in diabetic patients and less severe and shorter lasting common cold symptoms^{8,9}. While this literature shows that, a GP's empathy is a core value and major satisfier for patients, not much is known so far about patients' personal experiences with empathy, whether it be positive, or negative ones.

In addition, several developments in current GP practice, which possibly influence the above-mentioned aspects, should be taken into account. GPs increasingly have to deal with IT- and administrative requirements. Furthermore, primary care work has increasingly become teamwork, as GPs have to work closely together with other healthcare professionals¹⁰. These developments require more organizational arrangements and protocols^{11,12}. To many GPs this protocol-driven care is an important obstacle to showing empathic behaviour¹³.

Patients consider GPs to be responsible for the effectiveness of the medical consultation^{2,14}. It is worth mentioning that, in contrast to patients' opinions about the value of empathy, the GP's focus seems to have shifted to a more task-oriented approach, an emphasis on biomedical factors rather than the patient's emotional aspects, and to productivity and efficiency¹⁵⁻¹⁷.

The concept of empathy can be regarded to be a catch-all one; some scientists and theorists think of empathy as either emerging from more cognitive mechanisms or as an affective process, while others see the emotional and cognitive aspects as overlapping rather than separate¹⁸⁻²¹. Some have made a distinction between 'trait' empathy (parent-infant dyad) versus 'situational' empathy^{18,20,22}. To make matters even more confusing, the concepts of empathy, sympathy and compassion are often used interchangeably in today's healthcare literature²³.

Although Macnaughton (medical humanities) has questioned whether a physician can ever really "stand in the patient's shoes"²⁴, patients, as was stated earlier, on their part highly value empathy. A better understanding of patients' personal experiences with, expectations of and opinions on a GP's empathic behaviour could be instructive for the GP and GP practice at large and may result in more adequate GP practice consultations. However,

patients' personal experiences during GP practice consultations and their consequences have so far not been studied thoroughly. Therefore, this qualitative focus group study aims to explore patients' experiences of and opinions on empathy in the encounter in GP practice.

Methods

Study design

Five focus group sessions were conducted to explore participants' experiences and opinions with regard to empathy in GP practice. Each focus group consisted of six to seven participants recruited from the general population.

Focus group sessions were chosen as a research method, because they rely on group processes, resulting in a deeper exploration and clarification of patients' rationales, expectations and experiences²⁵. Furthermore, the size of the individual focus groups allows all participants to express their experiences and opinions²⁶. To elicit multiple aspects of empathy, we used a topic guide that was based on literature and expertise of the supervising committee and was tested for appropriateness and usefulness in two pilot focus groups (appendix 1). To progressively focus on the subject of our study, this topic guide was adapted in the course of the first four focus group interviews. The topic guide was further adapted for the fifth focus group (appendix 2).

Study population and procedures

A press report, in which participants were invited to apply for participation, was published in free public local newspapers (including their websites) in four Dutch regions. To ensure a heterogeneous distribution of the sample, we aimed at diversity in sex, age and level of education of participants. As more women and highly educated people responded to the first press report, a second appeal was issued specifically inviting men and people with lower education backgrounds to take part. Adults who had visited their GP at least once in the previous year were included. Persons who had been involved in a formal complaint procedure with a GP were excluded. Thirty persons agreed to participate and met criteria; two of these participants withdrew before the study started, due to illness.

Participants were given an explanation of the aims of the study and a guarantee of anonymity and confidentiality by mutual e-mail correspondence. They were also informed of the need to sign an informed consent form.

To avoid bias within the group process, the participants within each focus group did not know each other. There was no relationship between researchers and participants prior to study commencement.

Because of the ongoing debate about the usefulness of mixed or homogeneously composed groups²⁷, we decided to compose one mixed-gender group, three groups with only female

participants and one group with only male participants. A significant number of participants turned out to be or have been working in care, as for instance nurses or social workers. As we expected them to have specific perspectives as care-receivers and care-givers, we formed one focus group consisting solely of participants with a care background (see table 1).

The study was approved by the Regional Committee for Medical Research Ethics of the region Arnhem-Nijmegen (letter dd 10-8-2015, file number: 2015-330).

Table 1: Arrangement of the focus groups

Focus group number	Type, Abbreviation	Gender	Specific characteristics
00	Pilot	Mixed	
0	Pilot	Mixed	
1	MG.FG1	Mixed	
2	C.FG2	Female	Care background
3	M.FG3	Male	
4	F.FG4	Female	
5	F.FG5	Female	

Data collection

Each focus group session was moderated by an experienced female moderator with a GP-background (LV). The non-participating group observer (FD) took notes and made audio recordings of the sessions. The sessions lasted 90-110 minutes and were held at the Radboud university medical centre in November 2015 and March 2016. At the end of each session, the moderator summarized the discussion in order to evaluate the contribution of each of the participants and to establish whether participants agreed with the summary. After each session, the moderator and observer exchanged their preliminary impressions of communication between and participation of the group members. All the participants completed and signed informed consent forms. Participants were offered financial compensation for travel expenses and investment of time (a € 50,-voucher per person).

Data analysis

The observer transcribed the audio recording of each session to obtain a verbatim report. Transcripts of the focus group sessions were imported into qualitative analysis software, Atlas-ti 7. Analysis of the data was performed according to the principles of constant

comparative analysis²⁸. In order to progressively refine the focus group interview guide to explore the subject in depth, focus group discussions and analysis proceeded iteratively.

The data from the two pilot focus groups were analyzed by the GP-researcher with 35 years' experience in general practice (FD) and a female researcher with expertise in qualitative methods (AP). The data from the other five focus groups were analyzed by the same GP-researcher (FD), a female medical student with expertise in qualitative methods (AvD), and a male practicing GP with 10 years' experience in general practice and with expertise in qualitative and quantitative research methods (ToH). During the analysis of the five focus group discussions, researchers (FD, AvD) familiarized themselves with all data by repeatedly reading all the transcripts. Subsequently, applying open coding, the researchers independently unravelled segments of the texts and assigned keywords. Furthermore, every paragraph was thoroughly coded. These codes were compared and discussed several times and the agreed additional codes were applied to the transcripts. Weekly reflective moments were organized. In case of disagreement, the opinion of a third researcher was sought (ToH). Codes referring to the same phenomenon were grouped into categories, and categories were grouped into themes that represent important and relevant aspects of patients' experiences with and opinions on empathy in the clinical encounter. This process was repeated several times. After the fifth focus group, data saturation was reached.

The whole process was regularly reflected on and discussed by the entire research team, who read all the verbatim transcripts (FD, ToH, JB, AL). Quotes which underline the main results were presented and were translated by a near-native speaker, from Dutch into English. The consolidated criteria for reporting qualitative studies (COREQ) were applied²⁸.

Results

In total 28 patients took part in the focus group discussions. Most of the participants were older than 50, highly educated and female. An overview of the background characteristics of the participants is presented in table 2. Information on participants' socio-demographic characteristics and their motivation to participate was gathered by means of a questionnaire.

The analysis of the focus group interviews revealed that participants described empathy in terms of attitude, competences and behaviour. When speaking about 'attitude', participants mentioned aspects such as a GP's receptivity, commitment and authenticity. With regard to 'competences', participants wanted their GP to take them seriously, to make them feel welcome and to listen to them. A GP's empathic 'behaviour' was described as resulting in feelings of safety, trust and support. The majority of the participants described empathy as an important prerequisite of the GP's-commitment and a pivotal characteristic of communication in the GP practice encounter:

“To me, empathy is very important. It’s a sign of my GP’s commitment”(F.FG 5).

Furthermore, participants indicated they only felt sincerely listened to when a GP shows empathy:

“...because I think that listening is very important, and also that you feel that it’s authentic...” (C.FG2).

Describing their experiences and opinions, participants strongly focused on and discussed extensively what consequences the presence or absence of empathy in the GP encounter had on them.

Table 2: characteristics of 28 participants of the study

characteristics	N (%)
<i>Gender</i>	
Male	9 (32)
Female	19 (68)
<i>Educational level</i>	
Low	0 (0)
Middle (MBO)	8 (28)
High (HBO and Univ.)	20 (72)
<i>Age categories</i>	
<50	3 (10)
50-65	13 (47)
>65	12 (43)
<i>Occupation</i>	
Education	5 (19)
Services	15 (55)
Care	7 (26)

Personalized care and enablement when empathy is present

According to many participants, empathy in the GP practice encounter facilitates developing a relationship with their GPs from a strictly doctor-patient one to a more person-person one. This more personal relationship made participants feel more at ease, and it also made them

feel they were being helped in a more authentic and respectful manner. Participants indicated that their GP's empathic attitude as well as their empathic skills (e.g. creating the right atmosphere for an empathic dialogue) helped build such a relationship.

“For instance, that when you have a complaint, that you feel that your relationship with the GP is such that you can ask questions about it, that you're not afraid to ask questions” (F.FG5).

“I went there with my partner and when the GP asked me ‘How have things been for you?’ I felt heard and I thought ‘Yes, that’s a good opening, yes; you’ve got me on board now’. It made me feel very good” (F.FG4).

As a result of a GP's empathic behaviour (e.g. verbal or non-verbal signals and recognizing patient's feelings) participants described experiences of mutual openness, trust and safety, resulting in better attuned information, mutual understanding and a general feeling of being taken seriously.

“I think it makes you feel like you can be more open, and that can lead to getting what you need sooner, and possibly to a speedier recovery. When I'm more open, he can respond to that with a treatment or a conversation or whatever” (F.FG4).

“It allowed me to trust in her, which enabled me to stop worrying about it all the time..... you don't have to worry all the time about whether things will be OK the next time or about what they're doing to you” (F.FG5).

Additionally, when a GP's empathic behaviour was present, many participants felt they were being supported by their GP. This was important to them in order to develop adequate coping strategies to take control of their own situation.

“I had stopped working; my mother had died, and when I came to him complaining about my headaches – in hindsight obviously stress-related – he addressed those issues quite thoroughly, making me think for myself that these things could be related. Talking like that with him a couple of times and getting his advice really helped me through it” (F.FG4).

“She also gave me space to share my feelings and that was kind of confronting at times as well. It made me think about what I wanted and that turned everything around, allowing me to be positive again, to take back control, while taking account of my own feelings” (F.FG5).

Frustrations and stress when empathy is absent

With most participants viewing empathy as quite simply a prerequisite for a successful consultation, they clearly stated that the absence of empathy in the GP encounter can have a huge impact on the patient-GP relationship; participants become disappointed and feel an emotional distance. Participants indicated that this emotional distance may result in a lack of understanding and can hamper solving the symptoms and problems presented. Additionally, participants reported not feeling respected as unique and equal human beings:

“... when I was still with my old GP, I tried to let her know that I felt very uncomfortable with that, with her being so impatient with me. Her response was along the lines of ‘she was very busy and I just had to understand that’. To me, that’s not empathic at all” (C.FG2).

Participants described they felt frustrated, disempowered, upset, overwhelmed and abandoned, resulting in very stressful consultations. Furthermore, participants reported that they sometimes experienced arrogant, belittling and patronizing behaviour on the part of the GP.

“I felt abandoned, truly abandoned. So much so that it would keep me awake at night, thinking ‘how is this going to be in the future, we’re getting on a bit and getting more dependent, can I fall back on her, can I?’” (F.FG5).

“... it really feels like falling into a ravine, like being shunted off, which is all the more upsetting because you’re already sick and you really can’t have something like that when you’re sick” (MG.FG1).

Some participants reported they experienced much difficulty in discussing their GP’s lack of empathy. Experiencing a lack of empathy sometimes resulted in actions by participants such as writing a letter of complaint or a clarifying visit to the GP. However, in some cases the experienced lack of empathy resulted in avoiding visits to the GP.

“When a doctor shows a lack of empathy, I will consider taking another doctor, for it’s very important to me to feel understood” (M.FG3).

Nevertheless participants also made excuses for the GP’s non-empathic behaviour, whether on practical grounds (such as lack of time) or on more personal ones. Some participants indicated that they tried to improve their relationship with their GP by showing an interest in their private life.

“There is an age gap, of course – we’re a bit older ourselves and that makes you think like ‘these younger people have to work so hard, they have to watch the clock all

the time and do everything in a rush, with the health insurance companies breathing down their necks', so I'm aware that we're making excuses for their behaviour all the time" (F.FG5).

Potential pitfalls of empathy

Participants indicated that they sometimes experienced negative side effects of empathy. Although most participants regarded empathy as helpful in building a trustful and safe patient-GP relationship, but they were also wary of getting too close and being too open. They felt that too much trust and openness could lead to them sharing too much private information, which could possibly be handled by their GP in an unwelcome manner. Some participants even described how a GP showing what felt to them like excessive empathy could make them feel more concerned about their condition.

"When he treated me with so much empathy, I told him things that I later regretted. I can't take them back and I feel certain that he has used that information, to inform a colleague in spite of patient-doctor confidentiality" (M.FG3).

"My suspected infection should have been long over. My doctor was very empathetic, strikingly more so than usual. It scared me" (MG.FG1).

Participants also mentioned the possible effects of an excess of empathy on GPs' personal lives.

"I think it's in the doctor's best interest not to get too closely involved, for if he does it can easily encroach upon his private life and that shouldn't happen" (MG.FG1).

Discussion and conclusion

Discussion

This study clearly shows that participants are very aware of the impact of empathy in the GP practice encounter. Almost all participants stated that the GP showing empathy results in personal patient-GP relationships characterized by openness, trust and safety. Furthermore, it enhances the patient's coping behaviour and leads to a sense of enablement.

An experienced lack of empathy can result in stressful consultations in which participants feel disappointed, upset and overwhelmed. In the long term, a lack of empathy can lead to patients avoiding contact with their GP or even switching to another GP. However, some participants show a willingness to forgive GPs for their shortcomings in showing empathy, mentioning time pressures, red tape or simply not getting along on a personal level as potential reasons.

Participants also mentioned potential pitfalls of the use of empathy. An empathic approach by the GP can lead to the patient sharing what is later felt as too much private information, and even to anxiety about their condition.

Higher perceived GP empathy has been discussed recently as a significant independent predictor of symptom improvement a month after consultation²⁹. Furthermore, empathy strongly influences the interpersonal motivation of individuals to approach each other, and it guides social interaction and shapes relationships³⁰.

Our results provide a deeper insight into these aspects, as participants show how they observe and are very aware of the consequences of a lack of empathy in the primary care encounter. In spite of these negative consequences participants look for excuses – time pressure, red tape or personal differences – for the GPs' shortcomings. Recently Mazzi et al. have shown that patients consider sharing responsibility and behaving respectfully towards each other to be important within the patient-GP relationship (31). Additionally, patient loyalty – the patient's deeply felt commitment to GPs despite situational influences and marketing efforts – is strongly related to patient trust, good patient-GP relationships and patient satisfaction³². Our results suggest that the search for excuses by patients can be attributed to their loyalty; they protect their patient-GP relationship. However, one of the key issues raised in this study is that patient loyalty is not infinite. Participants indicate that a lack of empathy results in a difficult situation and can even result in avoidance of the GP or the decision to transfer to another GP, leading to obstacles in the path to adequate continuing primary care. Only Halpern, referring to medical care in a broad sense, discussed the possibility of patients transferring to other physicians as a possible result of a lack of emotion in a physician's communication³³. Other studies have shown that a lack of empathy can lead to disappointment with the healthcare system³⁴ or to an increase of malpractice suits³⁵. We have identified two other aspects of how GPs' empathic behaviour affects patients' experiences.

Firstly, we found that patients can experience empathy as a 'trap'. Observational studies have found a GP's empathic and emotionally attuned behaviour can lead to receiving more detailed information about the patient's condition^{33,36,37}. However, some of our participants expressed concern at being tempted to share too much private information. Moreover, some of them worried about how this information is handled. Also, it appeared that what is perceived by patients as an excess of GP empathy can result in them feeling more concerned about their condition. These findings are in line with the statement of Konrath et al. In their recent review¹⁸ they stated that "although empathy is nearly always a desirable attribute in relationships, it can have some apparently contradictory results". Therefore, professionals should be aware of the limits of empathy and take responsibility to protect patients' boundaries¹⁸.

Secondly, participants feel that the presence of empathy within the encounter in GP practice makes them feel supported results—in their search of adequate coping strategies. Recently, Mercer et al. found that enablement – the extent to which a patient, after a medical consultation, feels able to cope with, understand and manage his/her illness - does not occur when the patient perceives low levels of empathy in the doctor; they suggested that a GP's empathy is a basic prerequisite for patient enablement³⁸. Empathy is considered by them as one of the consultation factors associated with enablement. However, they do not discuss the connection between these two concepts in a detailed manner. Elaborating on this theme we hypothesize that a triangle between empathy, trust and enablement exists in consultations in GP practice. GP practices and the long-term patient-GP relationship on their own are regarded as important catalytic agents to identify patients' strengths^{39,40}. Empathy especially helps the GP to reach the patient in his/her illness and to value the patient as a person^{14,41}. Owing to this, the patient's sense of trust, self-control and of being known increases¹⁴, and these feelings of control and self-confidence activate the development of adequate coping strategies⁴². These assumptions are elucidated by our study's results and resemble the salutogenetic perspective which underpins the importance of acknowledging the patient as a person who is able to manage the situation him/herself and to mutually engage professionals and patients in a process⁴³.

Conclusion

Whenever empathy is present in patient-GP communication, patients feel heard and supported, which contributes to a trustful and effective patient-GP relationship and to new coping strategies.

If empathy is absent, patients experience stress and other negative feelings during and after consultations. These feelings result in patients avoiding their GP, which can make it difficult for patients to get adequate GP practice care. Patients sometimes make excuses for GPs' shortcomings in empathetic communication.

Practice implications

The narrative picture of the participants' positive emotions caused by the presence of empathy (increased personalized care, trust and support of coping strategies) and the negative emotions caused by the absence of empathy (disappointment and avoidance of visiting a GP) should guide GPs towards patient-GP communication in which empathy is a core element.

Furthermore, the study's results might provide instructive material for medical education. GPs, residents and medical students should be educated in more detail on how to use empathy as a tool to increase the beneficial effects of the consultation and to enable patients

to develop adequate coping strategies. They should also be educated to be aware of potential pitfalls of using empathy. At present, during vocational GP training, empathy in patient-GP communication is mostly dealt with implicitly in training communication skills^{44,45} and we hope that this study shows the urgent need for more explicit attention to empathy in GP education. During GP education only self-rated measures of empathy are applied⁴⁶; because of the instructiveness of the patients' experiences with empathy we suggest applying the patient-rated CARE-measure as well^{46,47}.

Strength of this study is its founding in daily GP practice. Focus group discussions allowed participants to share their stories and opinions and to express themselves freely. This revealed valuable insights into person-centred elements of the affective side of communication in GP practice.

Tape-recording the discussion, evaluating and checking the participants' contributions at the end of each session and multiple coding during the analysis added to the rigor of the study. However, there are some limitations to discuss. The qualitative data collected through the focus group interviews lack narratives of lower educated participants. Although the research team was aware of the lack of male and lower educated participants and actively tried to redress this imbalance, we did not fully succeed in this. It is possible that patients who were not accessed by this study view empathy differently from the slightly older, mostly female, middle class participants who took part.

Furthermore, with the moderator, focus group observer and analysers all having a GP-background, our interpretation of the data might be slightly biased. However, we are convinced that by including a behavioural scientist in the supervising committee (JB) this potential bias has been sufficiently redressed. As in all qualitative research, the purposive sample does not represent the views of the general population. However, it does represent a broad range of opinions in the population with regard to empathy in the GP practice encounter.

Conflict of interest

No funding was obtained for this study. The authors have no conflicts of interest to declare.

Authors' contributions

FD, JB, ToH and AL contributed to the concept and design of the study. FD, AP and AvD analyzed the data. FD, ToH, JB and AL drafted the manuscript and provided substantial input into revisions of the manuscript. All authors approved the final manuscript.

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Appendix 1: INTERVIEW GUIDELINES FOCUS GROUP.

Introduction by the moderator:

A warm welcome to all. I will first introduce myself, I am ... During this focus group I will function as a moderator. This means that I will present to you questions and that I will try, as far as possible, that anyone can speak freely. I will appoint you with the first name, that seems excessive, but is important for the elaboration of the audio tapes in finding who has said something. With this you takes part in a scientific research on empathy in communication between general practitioners and people who use general practice care. It is a qualitative form of research and takes place in the form of several focus groups. A focus group is a group of 6-7 participants who are found to be participate under the direction of a moderator and who want to talk about a topic together. This includes researching, identifying and describing the experiences and opinions of the participants. Within our research there will be organized multiple focus groups. We are looking for the greatest possible diversity of opinions on this topic, so both positive and negative. We find everyone's opinion important; therefore I would ask you not to talk to each other and to wait with a reaction until someone has ended. So feel free to report your experience or opinion; today you are the 'expert'. The entire conversation becomes audio recorded. You can be sure that the recordings will be treated strictly confidential. To indicate that you have understood everything and has no objection for the scientific use of the data you will first be asked to sign a form before that (we call that a "informed consent").

We are very grateful that you participate in this part of the research. The meeting takes about 1 ½ hour, briefly paused halfway. If there are no further questions you can now complete and sign the form of "informed consent".

My 1st question is a 'one by one' question; just some more explanation can be asked. The other questions are 'interaction questions'; You can directly interact.

Questions:

1. **Would you like to say who you are, would you tell something in brief about yourself, and why you are motivated to talk about empathy.**
2. **We're talking today about empathy. You may have thought about the subject. We are interested in how you defines it . Could you describe what empathy means for you. What is that anyway? You can also describe it with examples.**
3. **When we talk about a GP's empathy, can you describe your own experiences? Do you have examples in negative or positive sense?**
4. **Do you have an opinion about or could you define what influence empathy has on communicating with your GP?**

Frustrations and stress when empathy is absent

With most participants viewing empathy as quite simply a prerequisite for a successful consultation, they clearly stated that the absence of empathy in the GP encounter can have a huge impact on the patient-GP relationship; participants become disappointed and feel an emotional distance. Participants indicated that this emotional distance may result in a lack of understanding and can hamper solving the symptoms and problems presented. Additionally, participants reported not feeling respected as unique and equal human beings:

“... when I was still with my old GP, I tried to let her know that I felt very uncomfortable with that, with her being so impatient with me. Her response was along the lines of ‘she was very busy and I just had to understand that’. To me, that’s not empathic at all” (C.FG2).

Participants described they felt frustrated, disempowered, upset, overwhelmed and abandoned, resulting in very stressful consultations. Furthermore, participants reported that they sometimes experienced arrogant, belittling and patronizing behaviour on the part of the GP.

“I felt abandoned, truly abandoned. So much so that it would keep me awake at night, thinking ‘how is this going to be in the future, we’re getting on a bit and getting more dependent, can I fall back on her, can I?’” (F.FG5).

“... it really feels like falling into a ravine, like being shunted off, which is all the more upsetting because you’re already sick and you really can’t have something like that when you’re sick” (MG.FG1).

Some participants reported they experienced much difficulty in discussing their GP’s lack of empathy. Experiencing a lack of empathy sometimes resulted in actions by participants such as writing a letter of complaint or a clarifying visit to the GP. However, in some cases the experienced lack of empathy resulted in avoiding visits to the GP.

“When a doctor shows a lack of empathy, I will consider taking another doctor, for it’s very important to me to feel understood” (M.FG3).

Nevertheless participants also made excuses for the GP’s non-empathic behaviour, whether on practical grounds (such as lack of time) or on more personal ones. Some participants indicated that they tried to improve their relationship with their GP by showing an interest in their private life.

“There is an age gap, of course – we’re a bit older ourselves and that makes you think like ‘these younger people have to work so hard, they have to watch the clock all

Appendix 2: INTERVIEW GUIDELINE FOCUSGROUP 5.

Introduction by the moderator:

A warm welcome to all. I will first introduce myself, I am ... During this focus group I will function as a moderator. This means that I will present to you questions and that I will try, as far as possible, that anyone can speak freely. I will appoint you with the first name, that seems excessive, but is important for the elaboration of the audio tapes in finding who has said something. With this you takes part in a scientific research on empathy in communication between general practitioners and people who use general practice care. It is a qualitative form of research and takes place in the form of several focus groups. A focus group is a group of 6-7 participants who are found to be participate under the direction of a moderator and who want to talk about a topic together. This includes researching, identifying and describing the experiences and opinions of the participants. Within our research there will be organized multiple focus groups. We are looking for the greatest possible diversity of opinions on this topic, so both positive and negative. We find everyone's opinion important; therefore I would ask you not to talk to each other and to wait with a reaction until someone has ended. So feel free to report your experience or opinion; today you are the 'expert'. The entire conversation becomes audio recorded. You can be sure that the recordings will be treated strictly confidential. To indicate that you have understood everything and has no objection for the scientific use of the data you will first be asked to sign a form before that (we call that a "informed consent").

Within our study four focus groups have been organized until now. Their results have been analyzed; this analysis has lead to some subjects who need more detailed discussion with people. So we have some further questions.

We are very grateful that you participate in this part of the research. The meeting takes about 1 ½ hour, briefly paused halfway. If there are no further questions you can now complete and sign the form of "informed consent".

My 1st question is a 'one by one' question; just some more explanation can be asked. The other questions are 'interaction questions'; You can directly interact.

Questions:

- 1. Would you like to say who you are, would you tell something in brief about yourself, and why you are motivated to talk about empathy.**
- 2. We're talking today about empathy. You may have thought about the subject. We are interested in which positive and negative effects of empathy you experience; can you describe it and do you have examples.**
 - **So, which are the positive effects of empathy during GP-consultation?**

- And which negative effects of empathy do you experience consulting a GP?
3. Within other focus groups absence of empathy or wrong use of empathy by the GP has been discussed. Do you recognize this? Do you have examples or descriptions? Which are the consequences of such a GP's behaviour?
 4. Can you describe your own influence on the GP's empathic behaviour? Do you consider this important? And why?
 - So entering the GP's practice which are your own opportunities to look after empathic GP's communication and which own behaviour should you prevent?

Hereafter the moderator gives a brief summary of the answers on the key questions and the emerging ideas during the discussion and verifies that all group members find this an adequate summary.

- Do you have any important opinions or comments about the issues discussed that you missed and you'd like to share?

5

Empathy: what does it mean for General Practitioners? A qualitative study.

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"I do find it terribly important that this aspect has its place, that it's there, that people feel heard and seen, that they feel that they are being taken seriously and that they are getting attention; yes, if that were to be absent, I would not feel I was being a good doctor."

(a GP)

Background. Research has highlighted empathy as an important and effective factor in patient-physician communication. GPs have extensive practical experience with empathy. However, little is known about the personal views of GPs regarding the meaning and application of empathy in daily practice.

Objectives. To explore GP's experiences and the application of empathy in daily practice; to investigate the practical use of empathy. Facts such as preconditions, barriers and facilitating possibilities are described.

Methods. Qualitative interview study; 30 in-depth interviews were performed between June 2012 and January 2013 with a heterogeneous sample of Dutch GPs. Interviews were recorded and transcribed verbatim; content analysis was performed with the help of Atlas-ti.

Results. Empathy was seen as an important quality-increasing element during the patient-GP consultation. The application of non-verbal and verbal techniques was described. Attention to cues and references to previous consults were reported separately. Required preconditions were: being physically and mentally fit, feeling no time pressure and having an efficient practice organization. Not feeling connected to the patient, and strict medical guidelines and protocols were identified as obstacles. A key consideration was the positive contribution of empathy to job satisfaction.

Conclusions. The opinions of GPs in this research can be considered as supplementing and strengthening the findings of previous researches. The GPs In this study discussed, in particular, ideas important to the facilitation of empathy. These included: longer consultations; smaller practices; efficient telephonic triage by practice assistants; using intervention to help reflect on their work; and drawing financiers' attention to the effectiveness of empathy.

Keywords. Empathy, general practice, application, job satisfaction, facilitation, qualitative research.

Introduction

Empathy is considered an important requirement in patient-physician consultation^{1,2}. In health care, empathy is usually considered to be the competence of a physician to understand the patient's situation, perspective and feelings; to communicate that understanding and check its accuracy; and to act on that understanding in a helpful therapeutic way; there are cognitive, emotional and behavioural aspects¹. Its effectiveness has been empirically proven to contribute to: an increase in patient satisfaction, detailed knowledge of patients' symptoms and psychosocial concerns, and considerably more commitment to the proposed therapy on the part of the patient^{1-3,4-7}.

Recent research on patient experiences shows that empathic statements obtained the highest quality rating from all participants, irrespective of their background characteristic and nationality⁸. From the perspective of a patient an important part of the quality of care is an empathic doctor, who is willing to take the time to listen⁹.

In recent literature some authors have reported that there has been a rise, during the last decade, of the technological and biomedical aspects of care, and of more emphasis on effectiveness and productivity in family care^{10,11}. These developments can create barriers to empathic relationships¹¹. Other researchers call for more attention to be paid to the role of bureaucratization and consumerism¹². Changes in the consulting room, like the greater use of computers, also affect the communication¹³. There seems to be a danger that empathy, despite its proven effectiveness⁶ and the above-mentioned importance in the patient-GP consultation, is seen increasingly as a 'soft' aspect in general practice communication¹⁰.

In applying empathy in general practice, GPs are faced with a complex situation. They have to combine evidence-based medical knowledge and protocols with their own emotions, moral standards and intuitions, and those of their patients.

There is little research available that explores the personal thoughts and opinions of GPs on the practical use of empathy in daily practice. The objective of our study therefore is to explore how GPs experience and apply empathy in daily practice, and to investigate the problems they come across when using empathy.

Methods

Study design

The GPs were interviewed from June 2012 to January 2013. In-depth interviews were employed because, as a method for data collection in qualitative health research, these explore experiences in daily practice and the significance GPs attribute to them; they also give an insight into the priorities of participants¹⁴. In this article we applied the consolidated criteria for reporting qualitative research (COREQ)¹⁵.

Preparation and participants

Thirty-one interviews were undertaken. Prior to the interviews, 4 test-interviews were audio-taped and discussed with a research-assistant.

Participants were recruited from the NIVEL (Netherlands Institute for Health services research) GP-registrar. With help of a statistical employee a systematic random sampling was applied. In order to produce a heterogeneous sample and to achieve, as much as possible, a normal representation of Dutch GPs, characteristics such as: age (<45, 45-55, >55), gender, practice type (solo, duo, or group) and degree of urbanization were used in the selection process.

A total number of 147 GPs were selected and approached with a personal letter, explaining the subject of the research. Also the interviewer, as a retired GP, was introduced (see invitation letter).

The GPs were telephoned some weeks after receipt of the invitation. After 100 telephone-calls 31 GPs consented to participate. They also consented to the data being used for this research. The rest, 47 GPs of the totally selected, were placed on a reserve list. An appointment was made with the 31 GPs, and anonymity and confidentiality were ensured.

Data collection and analyses

The interviews were held face to face at the participating GPs own practice and lasted for between 45 and 70 minutes. All fieldwork was conducted by a single researcher (FD).

The interviews were based on an interview guide that in turn was based on literature and expert opinions (see interview guide). No repeat interviews were carried out. All interviews were recorded with audio equipment (one recording failed) and transcribed verbatim by the interviewer. After 8 interviews (which were part of the succeeded 30 research interviews), style and content were analyzed by two supervisors (TL and JB); this resulted in a more profound interviewing style and achieved more detailed information.

Creswell's¹⁴ guidelines state that 20-30 participants are sufficient for assuming saturation and a variety of perspectives. In our study we found that saturation occurred at approximately interview 20, no new topics were then introduced. Hereafter the next interviews were used to explore special aspects such as: GPs ideas regarding facilitation.

To analyze the data content analysis was employed¹⁶⁻¹⁸. The systematic examination of transcripts involved three members of the research team, the interviewer and two doctoral medical students (FD, SK, MvM). This team of three researchers was formed in order to minimize the influence of personal characteristics on the analysis of data. Atlas-ti (software package) was used to assist with registering, searching and coding the data. The researchers read and re-read the transcripts independently but met regularly to discuss the subjects and interpretations. In addition after 3, 12 and 30 interviews the coding process was

discussed with a supervisor (TL). By using axial and selective coding, codes and super codes were attributed to text segments. Codes referring to the same phenomenon were grouped in categories and significant themes and key concepts were made explicit and arranged. These themes formed the structure of the final result.

Results

Thirty GPs participated. The demographics of the participants show variability concerning gender, age, degree of urbanization and practice type and are representative of the total GP population as shown in Table 1.

Non-participation was checked: no time to participate in research (n=19), no affinity with the subject (n=2), poor health (n=2), wrong address or telephone number/unknown person (n=33) or no promised re-call after the first contact by telephone (n=14).

Table 1: Characteristics of GP interview sample; June 2012 until January 2013.

Characteristics of the 30 participating GPs	N (%)
<i>Sex</i>	
Male	13 (43)
Female	17 (56)
<i>Age</i>	
< 45 years	13 (43)
45-55 years	10 (33)
> 55 years	7 (22)
<i>Practice type</i>	
Solo	8 (26)
Duo	14 (46)
Group	8 (26)
<i>Degree of urbanization</i>	
Rural area	12 (40)
Urban area	18 (60)
<i>Health Centre</i>	
Yes	16 (53)
No	14 (46)
Mean experience as GP, years (range)	16 (2-33)

Defining and valuating empathy

At first, to develop a clear interpretation of the findings of this research it was considered useful to gain some insight into the interviewees own views on empathy. They were asked to give their own definition. The description of their answers can be found in table 2. The answers were coded and categorized with help of empathy levels (attitude, competency and behaviour) as has been discussed in earlier research⁶. Some views were common to many interviews. Openness to the patient was regarded as an important element and seen as a “communication skill” and an “attitude”. In other words the personal capacity to have respect for the patient’s thoughts and feelings.

As a ‘competency’, recognizing patients as equal human beings was highly emphasized and a ‘behaviour’ expressing empathy was highlighted (see table 2).

Participants were also asked to value the importance of empathy in daily practice, using a score of 1-10. The resulting scores showed that it was regarded to be an important part of the consultation; the average score appeared: 8.12 (see table 2).

The generated themes

The analysis of the interviews generated four themes, which will be described below. The themes are: the realization of empathic behaviour, preconditions and barriers, views on the facilitation of empathy and the positive effects of empathy.

The applied quotations were in Dutch; they are translated with help of a near-native speaker.

The realization of empathic behaviour

Many GPs described that empathy was shown through non-verbal and verbal skills.

Non-verbal skill

Most of the GPs regard non-verbal communication as a vital empathic skill. They mentioned: an interested facial expression, keeping eye contact and leaning backward or forward to emphasize listening. Some recognized the importance of physical contact like a hand on the shoulder or an embrace, or offering a handkerchief when the patient is crying:

“Often when I go and fetch a patient from the waiting-room I’ll say ‘Come on in’ (making welcoming gestures with her arms), and make them feel welcome.” (23, female, 55 years)

“Part of it is obviously putting it into words, like “how awful” or “that must be very upsetting for you”, but also, I’m not chained to my chair, I’m dynamic, sometimes I

walk over to the patient and put my arm around them...yes, it can be quite physical too.” (28, female, 61 years)

Verbal skill

Different kinds of verbal skills were mentioned such as: a relaxed tone of voice, pauses, interested listening, clarifying the question, summarizing and reflecting on the patients' thoughts and feelings. Specially mentioned were attention to 'cues' and reference to previous consults or events in the life of the patient:

“..... I listen very attentively to people and the cues are extremely important.” (11, male, 42 years)

“Well, when a patient comes for a new consultation I ask them how things turned out after their previous visit.” (9, female, 44 years)

Preconditions and barriers

Preconditions.

Most of the GPs deemed their own physical fitness and being free of private worries important preconditions to being empathic. GPs considered being genuine and respectful, reaching equality and a good atmosphere as essential. Furthermore the following aspects were mentioned: the absence of time-pressure, an efficient practice organization and not being disturbed by practice assistants or telephone calls. Some of them indicated that it was important not to have negative feelings based on issues from the past:

“That time I was definitely less empathic, because I was so tired, and I was hasty and short-tempered. I was simply exhausted, and that definitely affected my work. I'm certain that patients would have noticed; so these factors definitely play a part: how you feel, did you sleep well, are you hung-over, that kind of thing.” (11, male, 42 years)

When it is influenced by something, now or from the past, coming from yourself or from the person opposite to you, the signals which are transmitted can cause obstacles in the story.” (10, female, 59 years)

Barriers

A great number of interviewees described the necessity of feeling connected to the patient as an essential part of being able to work empathically. Reasons for the absence of a connection can be caused by aggression coming from a patient or a GP's own feeling of aversion, for instance in the case of a perpetrator of child abuse. Personal and organizational barriers were mentioned as well:

" You see, empathy comes more easily when there is a click with someone, and if there is some barrier, whether through signals from yourself or from the person sitting opposite you, the whole thing gets a lot harder." (10, female, 59 years)

Strict medical guidelines and standardized treatments, so-called managed care, were assessed as important obstacles to being empathic. They were considered a restriction, not allowing time and space for other important patient problems. Some GPs were worried about the emphasis on measuring the quality of care by the figures of a protocol what does not include the importance of empathy as a quality-indicator:

"...too much registration of less important things, while you should spend time on the real problems of that patient. Too much paperwork, looking at your screen and not at the patient."(2, male, 39 years)

"The fact is, delivering certain lab-figures to insurance companies is obligatory, good or bad quality of care isn't measurable by figures."(14, male, 50 years)

Views on the facilitation of empathy

Personal, practice-organizational and health-organizational views on the facilitation of empathy were mentioned as well.

Personal views.

Several interviewees stressed the importance of a more continuous support of professionalism through following specific refresher courses for consultation skills and through participation in intervision. Thus enabling self reflection, talking about doubts and emotions, and working on self-awareness:

"Intervision has taught me a lot about myself. Observing myself I was quite struck by how, even though I thought I could hide my feelings from the patient, I obviously can't: a lot can be deducted from my facial expression, or from the way I fiddle with

something or suddenly look away when I lose interest. You can learn so much from it.” (3, male, 52 years)

Practice-organizational views.

Many GPs emphasized the need to be able to spend more time with their patients as an important precondition and facilitation as well; consequently, longer consultation time. However, some of the interviewed GPs identified that initially it takes time to build an empathic relationship but that this approach becomes cost- and time-effective in the long run. A longer consultation time requires efficient telephonic triage by practice assistants and a more flexible system of appointments. A reduction of practice size was also seen as a possibility but should not, in their opinion, lead to a lower income:

“I would certainly prefer to have fewer patients; I think I could then do this part of my work.” (3, male, 52 years)

“There is a case to be made for smaller practices and standard consults of 15 minutes per patient, but that shouldn’t result in a lower income.” (11, male, 42 years)

Health-organizational views.

Various interviewees drew attention to the discrepancy between the importance they attach to empathy in daily practice and the attitude of health financiers. Even though, GPs were convinced that using empathy can help in cutting back costs, they noticed that financiers show a reluctance to give any attention to this. This lack of attention is probably caused by the difficulty of measuring the effects of empathy during a consultation.

Nevertheless, according to the GPs possibilities exist for facilitating the role of the financiers. They mentioned items such as: changing the payment methods, financial support in practice size reduction and financial compensation after following empathic skill-related trainings:

“They (the financiers) should reward it, and not finish us with the mean HbA1c score of our diabetic patients.” (28, female, 61 years)

“When the Government appreciates our work; empathy is something we employ, and when you consider the commitment to our patients, that’s a big part of the quality of our work. That quality, should be rewarded through facilitating and financing. “ (2, male, 39 years)

"I think it would be very good to compare similar practices and look at the differences that come up, like less referrals." (9, female, 44 years)

"...it would be like: we'll give you a bonus per patient when you can show that you've done something, for instance when you've followed a relevant course; you've got a kind of added value, a kind of GP-plus." (15, male, 55 years)

The positive effects of empathy

The positive effects of empathy for both GP and patient were also mentioned. Most GPs were convinced that the use of empathy makes a positive contribution to therapy adherence, receiving useful and detailed information, a better interpretation of complaints and improved diagnostics. This enabled GPs to deal better with the patient's problems and to achieve successful treatment:

"I think that when people feel you listen to them, they in turn listen to you, resulting in improved compliance and adherence and more tendency to listen to what you have to say." (2, male, 39 years)

A number of the participants conclude that applying empathy resulted in a greater job satisfaction:

"Well, being empathic is being sincere, and when I can stay close to myself and at the same time get close to a patient, it gives me a lot of satisfaction and feeling of calm." (20, female, 34 years)

"It makes you feel very good...; it's a valuable thing, it also gives you a whole lot of positive energy." (30, female, 57 years).

Discussion

To summarize, GPs in this research regarded empathy as an important element during consultation. It helps to recognize patients as equal human beings. Imagining the thoughts and feelings of patients and receptivity were mentioned. 'Showing' feelings of sympathy was also considered important. And, in addition empathy was seen as a positive factor that contributed to job satisfaction.

The prerequisites necessary to apply empathy were considered to be: being genuine and respectful and cultivating a good atmosphere and feelings of equality. Participants considered non-verbal aspects of empathic communication as very important, but verbal aspects such as: being alert to cues and referring to previous consults or life events were also regarded to be essential.

The interviewed GPs perceived: good physical fitness, being free of private worries, the absence of time-pressure, an efficient practice organization and not being disturbed by practice assistants or telephone calls as important preconditions for being empathic.

Not feeling connected to the patient and the existence of many medical guidelines and protocols were considered to be obstacles to empathy in daily practice.

To facilitate the preconditions and to address the obstacles interviewees offered different solutions or compromises. For example, in order to have the opportunity to reflect on their work organized intervision or Balint groups were regarded as essential. Furthermore, longer consultation time, efficient telephonic triage by practice assistants and smaller practices were suggested.

Drawing the attention of the financiers to the effectiveness of empathy was regarded as an opportunity. This, firstly because of the efficient and detailed exchange of information during consultations and secondly because of the time-cost effectiveness.

Following some of the present research findings will be discussed in more detail in relation to previous research.

To begin with participants in this study seemed to be aware of most of the elements found in literature defining empathy⁶ (see table 2).

Secondly the positive thoughts in this research about the effectiveness of empathy seem to be connected to job satisfaction. The exposure of this relationship is important and surprising; it is to a certain extent related to the results of earlier research. To illustrate, it was found that positive moments in GPs' relationships with patients are experienced as gratifying elements, which enrich professional life and give pleasure¹⁹. Furthermore, feelings of fulfillment, job satisfaction, achievement and pride have been found as positive side-effects of being empathic; in that way a defense against depression, compassion fatigue and burn-out^{12,20,21}. Other research has found that GPs with high levels of burnout showed less patient-centred communication²². Although some literature puts forward the assumption that a high level of empathy causes an emotional burden, possibly creating 'compassion fatigue'²³, even though specifically queried, none of the interviewees considered this as a negative side effect of being empathic.

In literature attention has already been paid to non-verbal and verbal ways of empathic communication^{3,5,24-28}. Interviewees in this study highlighted the importance of reacting to

'cues' as essential in verbal empathic communication. This observation can be seen as quite remarkable, as generally speaking physicians tend to miss most patients' 'cues' and even adopt behaviours that discourages disclosure. However, communication training improves the detection of 'cues'²⁹. Broadly speaking, 'cues' ought to be seen as subtle signals that relay the patient's emotional concerns. Recognizing and responding to these signals enhances gathering information and benefits the relationship^{30,31}.

Finally the concern raised by the respondents about the role of medical protocols and paperwork/computer requirements as 'straitjackets', by which attention to more important complaints, usually not-fitting these protocols is decreased, can be regarded as quite a new and important result which echoes the theoretically based assumptions of other studies³². Also the practical barriers of time pressure, practice organization, physical fitness and the more emotionally oriented problems of personal worries, and negative past feelings, partly mentioned elsewhere³³, were well recognized in this study.

Additionally to these aspects interviewees in this study particularly discussed supplementary ideas on how to improve and facilitate the use of empathy. Although there is insufficient evidence and divided support for the hypothesis that the completion of special communication courses and Balint-training has any tangible effect, participants felt it would be beneficial³⁴⁻³⁶. The opportunity to reflect on work and experiences with other professionals would give support and insight into their own roles, skills and emotional balances. It would also help provide insight into the effect of an empathic approach to patient-doctor relationships. It was deemed essential that this kind of intervention should have recognized certification.

Longer consulting time and smaller practices were also highlighted as possibilities for facilitating empathy. In the long run the cost- and time-effectiveness of empathy is seen by the GPs as a positive facilitating element and a solid discussion point to promote the interest of financiers. This firmly supports the ideas of Neumann et al. who already highlighted the need for investigating this element^{7,37}.

Implications and recommendations

Empathy is a two way process, so it is essential attention should be given to the patients viewpoints about empathy during consultation.

Furthermore, if the conclusions of this research can be generalized, further detailed research should be done into the views of GPs on the facilitation of empathy in daily practice and on their thoughts about the borders between intimacy and professional autonomy. Research into the existence of awareness in general practice about a connection between empathy and aspects such as a patient-oriented approach and relationship-centred care could also be proposed.

Considering the results of this research a possible next step would be a study of the obstructing effects of protocol-based care. It would be interesting and inspiring to study the views of financiers on the role of empathy in GP's daily practice.

Throughout the training of GPs programs should be continued to provide students with empathic tools; attention should be given to the development of competencies like alertness to 'cues' and referring to previous consults or life events. Training-programs should also be aware of the personal development of students.

Strengths and limitations

To the best of our knowledge, the focus on GP's personal experiences and subjective interpretations of empathy is a significant and hitherto under-researched aspect of the GP's daily practice.

Being interviewed by a colleague, as an active participant, may affect the data collection³⁸. Despite this, considered as mutual confidants, interviewees may have given more detailed information. Some respondents experienced the opportunity to talk reflectively about their views as fascinating and clarifying, underlined the importance of this research and were curious about the results. The negative aspects of such a 'shared' relationship could be too little objectivity on the interviewer's part and giving socially desirable answers on the participants' part.

A weakness in this research could be that the GPs who consented to participate are likely to have a positive interest in the issue of empathy. This may influence their answers and could affect the interpretation of the findings. Underexposure of negative ideas about empathy is a possibility. So we are cautious about transferring findings directly to daily practice or in generalizing the ideas.

Conclusion

Although the interviewed GPs in this study volunteered to discuss empathy and showed for the most part positive ideas about the position of empathy in daily practice, the findings also offer additional information about some aspects of empathy in patient-GP consultation. Previously unexplored in GP-research are the attention to 'cues' during the consult and the reference to previous consults or life events as specific empathic skills.

GPs described feeling connected as a basic need in empathic behaviour; this connection needs preconditions and meets obstacles. In this research GPs specifically discussed ways of overcoming these barriers. They were positive about facilitating possibilities as: organizing intervention, more time for the patient, efficient practice organization and using the empirically proven effective benefits of empathy in discussions with financiers.

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Conflict of interest: none

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6

Managing barriers to empathy in the clinical encounter: a qualitative interview study with GPs.

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“I think it damages empathic communication with patients. Every now and then you just have to talk about things that are not in the guidelines. I think that is important for the relationship that you have with patients. If, for instance, a patient comes to me to have her blood pressure checked and I know that her husband died a few months ago, I do find it important to ask her how she is coping.”

(a GP)

Abstract**Background**

Current daily general practice has become increasingly technical and somatically oriented (where attention to patients' feelings is decreased) due to an increase in protocol-based guidelines. Priorities in GP–patient communication have shifted from a focus on listening and empathy to task-oriented communication.

Aim

To explore what barriers GPs experience when applying empathy in daily practice, and how these barriers are managed.

Design and setting

Thirty Dutch GPs with sufficient heterogeneity in sex, age, type of practice, and rural or urban setting were interviewed.

Method

The consolidated criteria for reporting qualitative research (COREQ) were applied. The verbatim transcripts were then analysed.

Results

According to participating GPs, the current emphasis on protocol-driven care can be a significant barrier to genuineness in communication. Other potential barriers mentioned were time pressures and constraints, and dealing with patients displaying 'unruly behaviour' or those with personality disorders. GPs indicated that it can be difficult to balance emotional involvement and professional distance. Longer consulting times, smaller practice populations, and efficient practice organization were described as practical solutions. In order to focus on a patient-as-person approach, GPs strongly suggested that deviating from guidelines should be possible when necessary as an element of good-quality care. Joining intercollegiate counseling groups was also discussed.

Conclusion

In addition to practical solutions for barriers to behaving empathically, GPs indicated that they needed more freedom to balance working with protocols and guidelines, as well as a patient-as-person and patient-as-partner approach. This balance is necessary to remain connected with patients and to deliver care that is truly personal.

Keywords

Empathic behaviour; empathy; patient-centred care; primary health care; protocol-driven care; shared responsibility.

INTRODUCTION

Caring for the 'whole person' in a holistic manner is at the foundation of primary care and is regarded as a basic expertise for GPs.¹ 'Whole-person care' means '... integrating a biomedical, psychological, social, cultural and holistic knowledge of the patient and community and applying this understanding to practical care planning through person-centred approaches ...'.² However, this person-centred approach is under pressure nowadays. Over the past decades, priorities in doctor–patient communication in everyday practice have shifted, from focusing on listening and empathy to task-oriented communication.³ As a result of protocol-based guidelines, daily practice has become increasingly technical and somatically oriented.⁴ A biomedical mainstream of care may be life-saving and health-promoting but it risks neglecting the patient's experiences of illness; understanding this is essential to ensure shared decision making based on the individual patient's perspective, preferences, and needs,^{5–9} and contributes to effective health care.¹⁰

The emphasis in general practice on evidence-based and protocol-driven care, and the observed reduction in viewing the patient as an individual, has caused an ideological debate.^{6,11,12} To achieve insight into different factors playing a role in GP–patient communication, models of the medical consultation were constructed.^{9,13} In these models, empathy was regarded as an important tool to establish a person-centred approach. By empathy the authors mean that a physician:^{14,15}

- understands the patient's situation, perspective, and feelings;
- communicates that understanding and checks its accuracy; and
- acts on that understanding in a helpful, therapeutic way.

Empathy implies a morally valuable aspect, namely the recognition of the other as the centre of their own experience.¹⁶

The effectiveness of empathy on specific clinical outcomes for patients has been widely proven¹⁷ and GPs view empathy as an important element during consultations.¹⁸ However, so far there have been no thorough studies into what barriers GPs experience in applying empathy in daily practice and how they manage these barriers, especially in the light of the aforementioned changes in communication in the medical consultation. Therefore, this study aims to examine barriers to GPs expressing empathy and how they manage these barriers.

METHOD

Study design

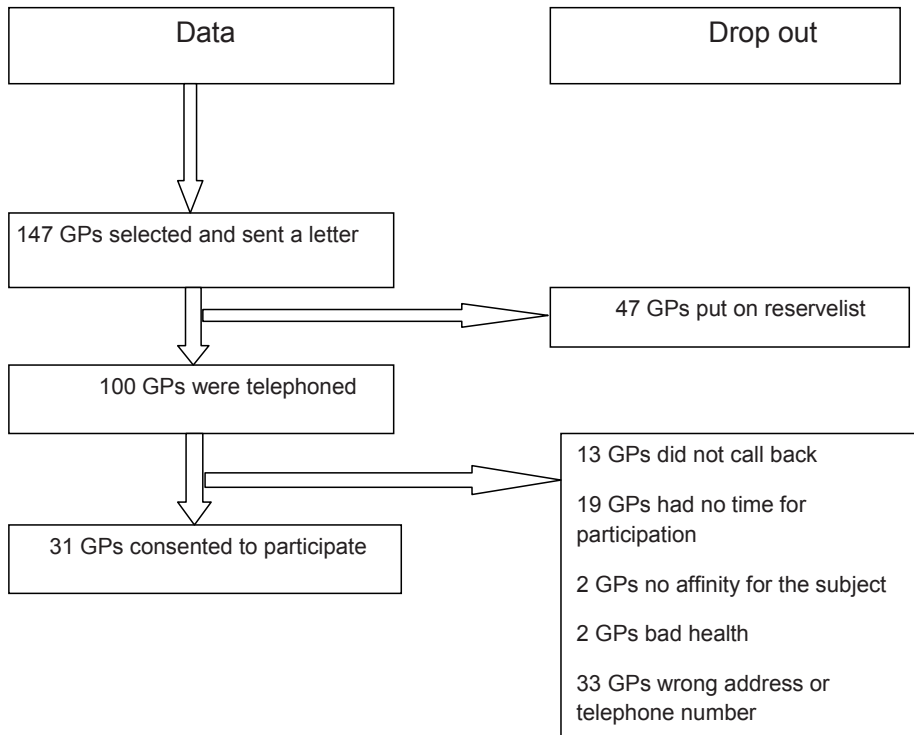
This study was carried out in the Netherlands where primary care is delivered by a GP and where patients are registered on their practice list. Most GPs cooperate in first-line health centers where they often help out with other GPs and health professionals such as specialized practice nurses, and with practice assistants. After medical school and internships, GP residents follow 3 years of postgraduate vocational training. Since 1989 the Dutch College of GPs has published more than 100 standardized protocols on different diseases prevalent in primary care.¹⁹

For this study GPs were interviewed between June 2012 and January 2013. In-depth interviews were performed because they enable experiences in daily practice and the meanings interviewees attribute to them to be explored. Furthermore, they clarify participants' opinions about their own priorities.^{20,21} The consolidated criteria for reporting qualitative research (COREQ) were applied.²²

Preparation and participants

Thirty-one interviews were conducted. To establish the appropriateness of the questions, four test interviews were performed by the first author; these were audiotaped and discussed by the first author within the research group.

Participants were recruited using a step-by-step procedure. To avoid the possibility of interviews taking place between people who knew each other, a statistical employee performed a systematic random sampling from the NIVEL (Netherlands Institute for Health Services Research) GP register (which includes all practicing Dutch GPs). To produce a maximum variation sample, characteristics such as age (<45, 45–55, >55 years), sex, practice type (solo, being one GP in a practice and duo being two, or a group practice), and grade of urbanization were taken into account. A total number of 147 GPs were selected and approached by letter, explaining the subject of the study and the duration of the interview. Some weeks after this letter was sent, the GPs were contacted by telephone. After 100 telephone calls, 31 GPs with sufficient variety in the aforementioned characteristics had consented to take part and signed an informed consent form. The 47 GPs who were not telephoned were placed on a reserve list (Figure 1). Appointments were made with the 31 GPs; anonymity and confidentiality were guaranteed.

Figure 1 Participants flowchart**Data collection**

The interviews were held face to face at the GPs' own practices and lasted between 45 and 70 minutes. All fieldwork was conducted by one author with a background in general practice who was an experienced interviewer.

The interviews were based on an interview guide formulated by the lead author and based on literature and expert opinions (Appendix 1). No repeat interviews were carried out. At the end of each interview the interviewee was given a short summary and was asked if they agreed with it. All interviews were recorded on audiotape and transcribed verbatim (in Dutch). After the first eight interviews, the interviewing style was analysed. After this, more open-ended questions were introduced to achieve more probing interviews and more room for reflection.

After 20 interviews it became clear that no new issues were arising. Although the first 20 interviews approached various aspects of empathy, the issue of barriers to empathy and how to manage these turned out to be the topic that came up the most. Therefore, the final 10

interviews were used to focus even more on the barriers GPs experienced in applying empathy during consultations and the way they managed these barriers.

Data analysis

To analyse the data, iterative content analysis was employed.²³ The systematic examination of transcripts was undertaken by the interviewer and two doctoral medical students trained in qualitative analysis. This team of researchers was formed to minimize the influence of personal characteristics on the analysis and thus the possibility of bias. Atlas.ti (version 7) was used to assist with registering, searching, and coding the data. The researchers, independently of one another, read and re-read the transcripts, and met regularly to discuss the subjects and interpretations. In addition, after the third, twelfth, and thirtieth interview, the coding process was discussed with one author acting as supervisor. By using axial and selective coding, codes and super codes were attributed to text segments. Codes referring to the same phenomenon were grouped in categories and significant themes were made explicit. These themes formed the structure of the final result; quotations were used to explicate the themes. The original quotations were in Dutch and were translated into English with the help of a near-native speaker.

RESULTS

Overview of the results

Thirty-one GPs participated but, because one recording failed, the study was based on 30 interviews. The demographics of the participants show variability concerning sex, age, degree of urbanization, and practice type (Table 1). An algorithm showing the procedure by which participants were recruited and information about those GPs not willing to participate is presented in Figure 1.

GPs indicated that they encounter barriers when they apply empathic behaviour in daily practice. However, because they consider empathy in the clinical encounter to be very important, they emphasized ways to manage these barriers. Four main barriers were distinguished:

- a conflict between protocol-driven care and showing genuine interest;
 - a tension between professional distance and emotional involvement;
 - patients' behaviour threatening connectedness within the GP-patient communication;
- and
- a conflict between time pressures and constraints and the GPs' need for personal space, peace, and need to regroup after each encounter.

These barriers and the ways that GPs manage them so that they can continue to show empathy are described below.

Table 1. Characteristics of the participating GPs

Characteristics of the 31 ^a participating GPs	N (%)
Sex	
Male	14 (45)
Female	17 (55)
Age, years	
<45	13 (42)
45–55	10 (32)
>55	8 (26)
Practice type	
Sole	8 (26)
Two partners (duo)	14 (45)
Group	9 (29)
Urbanisation	
Rural area	12 (39)
Urban area	19 (61)
Mean experience as GP, years (range)	16 (2–33)

^aThirty-one GPs participated but, because one recording failed, the study was based on 30 interviews.

Protocol-driven care versus showing genuine interest

GPs considered empathy to be an important prerequisite for humane care. However, they found that guideline-driven care results in a disease-centred emphasis rather than a person-centred way of thinking and working. The increased number of guidelines and bureaucratic requirements were seen as significant barriers to behaving empathically during the consultation.

Six GPs also mentioned that therapeutic regimens and ‘programmed asking’ (a list of standard questions) from evidence-based guidelines and protocols hamper genuine reactions, interest, and creativity, thereby reducing the effectiveness of their empathic behaviour. This programmed way of working in the current medical system was identified as an external barrier to providing empathic care:

‘... that we’re working in an extremely protocolised way, in fact being the doormat of the health insurance companies, that when I witness a resident doing a cardiovascular risk

protocol, reading out 30 questions to the patient and looking at the computer screen all the time, and I tell them they were doing that, they will hate it as much as I do, but that is the danger of working with protocols ... and it causes you to completely miss out on contact with the patient, and empathy suffers enormously, I think.' (GP 12, male, age 40 years)

'In my experience, the more you're doing your own thing, like I want this and I need that, the more you're doing that, the less you really listen. That way you run the risk of missing things in a patient and later you think, if I had just kept quiet for a moment and listened, if I had just taken a little bit more time, I would have picked up on things that would have changed the situation and the patient would have been more satisfied.' (GP 3, male, age 58 years)

'People with diabetes, for instance, they have to record about 73 items in a list ... and I thoroughly dislike that, because you're spending most of your time looking at the computer screen instead of at the patient, so, yes, the increase in administrative tasks does influence my communication ...' (GP 2, male, age 40 years)

To maintain their humane, empathic behaviour, GPs suggested that it is more effective and natural to combine the recommendations in the guidelines with questions about the patient's personal situation. GPs indicated that they considered patients as equal human beings, and that they wanted to treat them with respect and to show genuine interest, for example, by telephoning patients proactively in case of hospital admissions or life events, or by reflecting on previous situations. Furthermore, according to GPs, it helps to mutually value each other's expertise: the GP with regard to medical knowledge and the patient with regard to their specific situation and illness experiences. This patient-as-person approach contributed, in their view, to an innately humane form of contact, enhancing mutual understanding, shared responsibility, and commitment, and it helped to develop a trusting relationship:

'Empathy also means asking further questions: how are the kids, or if you know the husband is recovering from an illness, how is your husband doing? When the woman is visiting you to have her blood pressure checked, it is interesting to let go of protocol for a minute and ask after her husband, thereby showing interest in her context and broadening the picture; I can see that it's greatly appreciated, and it also gives me a lot of information about how she's doing.' (GP 13, male, age 37 years)

'Empathy also involves a certain disposition, an outlook on how you want to deal with a person ... I believe that patients can put forward their own expertise, to which I add mine,

and together we can then explore the problem and get to work ... it's like building a foundation for cooperation with the patient.' (GP 23, female, age 55 years)

Professional distance versus emotional involvement

The risks of getting too close to and emotionally involved with patients emerged during the interviews, with GPs concluding that such relationships may interfere with their objective judgement with regard to diagnosis and treatment. At the same time, GPs stated that they needed a certain level of involvement in order to behave empathically. Furthermore, according to GPs, when involvement becomes too intense, they risk developing burnout:

'That sometimes you start to cry when something is really tough, that has happened to me a few times. It makes me think less clearly and that is not good, so for me that's a boundary I don't want to cross. I think it's fine to be sympathetic with someone, but I shouldn't start blubbering along, that's not what I'm there for and I don't want to go there, and I think I can be more empathetic when I'm not eaten up by it.' (GP 9, female, age 55 years)

GPs mentioned ways to protect their professionalism, for example, by setting clear boundaries and creating distance in their doctor–patient contact by behaving in a business-like way.

Furthermore, they were convinced that intercollegiate counseling groups offer an excellent opportunity to discuss this issue in depth:

'Of course, there are moments when there is a lot of pressure, for example during palliative care ... when a different connection with someone develops, you must try to remain professional, which is quite difficult and I try not to show that to my patient. When necessary I can show my emotions to my partner at home or during counseling with colleagues.' (GP 17, female, age 36 years)

'There is a boundary and I can work with that. I think it's OK to have emotions, as a GP it's OK to show you have feelings and you're not a business-like person, you can express your feelings, but there is a boundary and that is your professionalism.' (GP 18, female, age 34 years)

Patients' behaviour threatening connectedness within GP–patient communication

GPs indicated that certain patients' characteristics can hamper GP–patient contact and complicate spontaneous and honest empathic communication. GPs specifically mentioned problems with the 'unruly behaviour' of some patients, such as those who argue aggressively with the reception staff, patients who keep an emotional distance, those with personality disorders, or patients who cross moral boundaries such as actively engaging in sexual abuse or drug dealing:

'They sometimes fend it off, they build up a wall, like "What is it, what do they want." That occurs pretty regularly here, with older men of the rough-diamond type, they don't say much but do come, and I think that can be tough, but if you approach them more quietly, you do sometimes get through to them, but I do find it tough sometimes.' (GP 17, female, age 36 years)

'When I get the feeling ... it does happen that you have to deal with someone and you just don't click. "You can't please them all." So there are people you just don't get along with, but that usually filters itself out, people switch to another GP and so they should.' (GP 5, male, age 65 years)

As a prerequisite for empathic behaviour in these situations, GPs emphasized that they need to be able to communicate in a free and honest way. They stated that their residency training in communication styles and intervision courses (Balint groups or coaching groups) help them to stay on speaking terms with these patients, preserving a trusting doctor–patient relationship:

'Really wishing the other person to have a good consultation, even if they enter all grumpy. It can be pretty tough in a situation like that to find out what is bothering them.' (GP 23, female, age 55 years)

'What I want to say is that it doesn't simply happen by "switching on", so yes, I'm all for supervision and intervision for GPs. In my opinion it is very important to experience personal growth, you could say that "growing and pruning" is my motto.' (GP 8, female, age 37 years)

Every day time pressures and constraints versus GPs' personal space and peace

GPs indicated that it is more difficult to pay empathic attention to the patient when the consultation schedule is overloaded. Overcrowded waiting rooms and large numbers of patients get in the way of empathy. Disturbance to the consultation itself, for example, because of incoming telephone calls, has a negative influence on GPs' attention and

communication. Furthermore, GPs indicated that personal factors also play an important role in hindering empathic attention. For example, reduced physical fitness, personal difficulties, or a recent night shift can result in a decrease in a GP's ability to show empathy:

'Well, it is affected by how you feel, how well you've slept ... you do have an off-day sometimes, and if you're doing consultations with a splitting headache, you know, it can be difficult to be really empathic; so yes, it does have to do with the condition you're in yourself.' (GP 29, female, age 64 years)

'Being distracted, someone entering ... when you're distracted it's hard to focus on a conversation, whether it be from being tired, or busy, or having all sorts of thoughts running through your head, there are phone calls and messages all the time. I think all those things can interfere.' (GP 9, female, age 45 years)

To manage these barriers, GPs stated that they try to plan longer consultation times for specific patients. In addition, they indicated that having a thoughtful and committed practice assistant who predicts patients' required consultation times helps them apply empathy. Furthermore, optimizing the organization of the consultation hours by structured deliberations between GPs and practice assistants was regarded by some as useful. Others saw a reduction in the number of registered patients as an opportunity to create extra time:

'Wouldn't it be an idea to switch to smaller practices and to spend 15 minutes on each patient, while keeping your income ... that way you'd actually facilitate empathy by keeping incomes at the same level ... I think there's certainly a case for setting a 15-minute consultation time for many complaints.' (GP 12, male, age 40 years)

'So that is an important prerequisite, you know, having peace of mind, things running smoothly in the practice. Your staff need to understand when they can interrupt you and when they cannot, and that some questions are worth an interruption and others are not; that's a matter of fine-tuning things.' (GP 16, male, age 45 years)

DISCUSSION

Summary

This study describes the barriers GPs encounter when applying empathy in daily practice and how they manage these barriers. GPs perceive the current emphasis on protocol-driven care with guidelines, bureaucratic requirements, pay-for-performance, and quality-of-care indicators to be an important barrier to remaining genuinely patient-oriented during the consultation. Although the government is not driving these changes, health insurance

organizations use, for example, blood levels (an HbA1c value from the diabetes protocol) as quality-of-care indicators.

To manage these barriers GPs try to combine a patient-as-person approach with the recommendations given in the guidelines. GPs mentioned overcrowded office hours and disturbances in consultations as factors hampering empathic behaviour. Longer consulting times, smaller practice populations, and efficient practice organization were described as practical solutions. Furthermore, GPs argued that approaching patients as partners with mutual expertise can result in shared responsibility. Conversely, they described how having to deal with transgressive behaviour in patients, those exhibiting unruly behaviour, those with personality disorders, and those keeping an emotional distance presented a barrier to displaying empathy in a spontaneous way. GPs also discussed their own internal difficulties in balancing emotional involvement and professional distance.

Strengths and limitations

GPs' experiences with barriers to empathetic behaviour and the ways they manage these barriers during consultations are, to the best of the authors' knowledge, hitherto under-researched aspects of GPs' everyday practice. Previous studies have explored the views of GP trainees, medical educators, and hospital specialists, or have approached the subject theoretically.^{9,24}

Being interviewed by a colleague has possibly affected the data collection.²⁵ Negatively, it could result in a lack of objectivity and possible bias, and, with respect to the participants, the possibility of them providing 'desirable' answers. Positively, being interviewed by a trustworthy colleague may have led GPs to give more personally detailed information.

Empathy can be considered a 'container' concept. Some interviewees merged it with aspects of general communication or patient-centredness. Qualitative studies are limited in their generalizability. However, compared with quantitative studies, they can provide richer insights. By using a cyclical and iterative way of collecting and analysing data, 'progressive focusing' on the barriers that GPs encounter and on the way these barriers are managed was realized. The GPs who participated did so as volunteers. Accepting a time-consuming interview may imply that GPs had some sympathy with the subject and may have under-exposed negative thoughts. Therefore, caution should be taken in generalizing conclusions beyond this study.

Although the qualitative method is appropriate to explore and clarify GPs' opinions, it does not provide insight into the GPs' actual behaviour. However, tape- recording the interviews, multiple coding during analysis, and member checks added to the rigor of the study.

Comparison with existing literature

Previous research has pointed out that communication styles of GPs have changed from focusing on listening and empathy towards task-oriented communication.²⁶ It can be assumed that this task-oriented communication originates from the ever-expanding numbers of standardized protocols and guidelines. Recently, health insurance companies have focused on the GP guidelines — which were not intended to be used in this way²⁷ — in order to define quality-of-care indicators for primary care. These indicators are mostly somatically oriented. Van Os and colleagues pointed out that merely following guidelines is not enough to deliver good-quality care.²⁸ The best outcome will be gained when doctors follow the professional guidelines and are able to build a trustful and personal doctor–patient relationship with their patients as well. Therefore, evaluating the quality of health care simply by measuring adherence to the guidelines is not appropriate at all.^{10,29} This explains the tension GPs face when they try to deliver good-quality health care. It is also in line with what patients expect: they count on a humane and personal approach from their GP, who shows an affective attitude and who is aware of the latest evidence available, and who takes the needs and consequences of their illness into account.^{10,30,31} In this regard patients have previously identified certain types of non-verbal behaviour of GPs, such as being occupied by the computer screen, as negative.³¹

Furthermore, this study highlights that empathy helps GPs to consider patients as so-called cooperating experts, an approach with shared responsibility and expertise, enabling tailor-made solutions. Previous research has defined the mutual-expert approach as partnership-building, a working alliance, or as achieving collaboration.^{9,32,33}

To choose the best course of action for the individual patient, Greenhalgh and colleagues argue that evidence-based medicine should reintroduce its founding principles, that is, a strong interpersonal, humanistic, and professional relationship, empathetic listening, and a collaboration between an expert physician and an expert patient.³⁴ GPs expressed exactly the same opinion in this study.

Preserving a more emotionally involved GP–patient relationship does have consequences. GPs in this study experienced tension between behaving empathically and remaining professional. They described how engaging empathy brings with it a need to create a balance between involvement and preserving some distance. The authors are not aware of recent general-practice-oriented studies analysing GPs' experiences regarding these aspects. Ethicists such as Gelhaus point to the depth of emotional participation of GPs in enabling adequate empathic understanding.³⁵ Previous theoretically oriented studies describe similar ideas about working on the boundary of self–other awareness. It is stated that mental flexibility, self-critical analysis, and self-knowledge help in maintaining a clear

self–other separation. Self-knowledge allows one to have a controlled, balanced, and efficient regulatory process of empathy-related responding.^{35–37}

Implications for research and practice

Given the results of this study, there is a need to get quantitative insight into the prevalence and relevance of barriers to empathic behaviour in daily practice. The consequences of overly biomedical protocol-driven care especially should be studied in depth, as well as the influence of the role of health insurance companies on patient-centred care.³⁸ The urgency of resolving the barriers experienced by GPs should also be determined. Further research in this area may be helpful to convince policymakers and health insurance companies to take action and to stimulate positive conditions for empathic behaviour in GPs. Because patients are considered important judges on healthcare issues,^{39,40} and research into patient outcomes has been performed,⁴¹ the authors advocate more detailed research into patients' experiences and opinions with regard to GPs' empathetic behaviour. Insight into patients' points of view gives physicians the opportunity to act on them.⁴²

According to GPs, empathy is a requisite for high-quality person-centred care, GP education should then focus on this to show students and residents the added value of empathetic behaviour. Teaching and practicing this behaviour should be embedded explicitly in the current teaching models on GP–patient communication. A focus on personal development and the introduction of humanities within GP education and residency may preserve and strengthen empathy as a humanizing communication skill in general practice.⁴³ Furthermore, continuous medical education and organizing intercollegiate counseling groups may help GPs in preserving an effective GP–patient relationship and in managing involvement with patients, while at the same time maintaining professional objectivity.

Conclusion

GPs described different kinds of barriers to their empathetic behaviour. They pointed out different ways to manage these barriers to preserve the role of empathy in GP–patient communication. In a healthcare system in which protocol-driven care and quality indicators have become increasingly important, GPs consider empathy as a fundamental tool in their patient-as-person and patient-as-partner approach. GPs in this study also stated that it is sometimes necessary to deviate from the recommendations described in the guidelines, in order to deliver high-quality person-centred care and to show a genuine interest in their patients.

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Appendix

Interview guidelines

Introduction: My name is Frans Derksen and I am a retired GP. I do a scientific research on empathy in patient- GP communication. As I mentioned in my letter of introduction, I am interested in the personal opinions, experiences and perceptions of both GPs and patients on the role of empathy during consults. This part of my research focuses on GPs; in a later phase the opinions of patients will be investigated.

I have chosen the face-to-face interview as the method to collect the data for this research. Names and addresses of GPs to approach were obtained through taking a sample from the NIVEL GP-file. You were in that sample and you have shown yourself willing to get involved with this research. Thank you for that.

In the interview I would like to talk to you about the following topics: background information about your practice, your views on general practice, your views on empathy in communication with the patient, and finally the conditions that you believe play a role when working with empathy.

I would like to stress that in this interview there will be plenty of space for your thoughts. My aim is to let the interview take up about an hour (about 15 minutes per topic).

As we have agreed, I will audiotape the entire interview; every now and then I will make notes and check my list of questions.

Of course everything you say is strictly confidential; the research findings will be anonymized.

Do you have any questions at this point?

Some questions to gain background information on your practice:

do you work in an urban or a rural area, when did you start working as a GP, do you train GP students; could you tell me something about your practice organization (solo, duo, group) and about your patients population?

(A)First your own general views on general practice:

- 1) At some point in your life you chose to become a GP. How did you come to that choice?
- 2) What aspects would you describe as the core of your job?
- 3) What important developments have you noticed during the time you have been a GP?
- 4) What do you think of these developments?

- 5) How do you feel now about your choice to become a GP, taking into the developments that you just outlined?

(B) Now I would like to talk to you about empathy:

- 1) What does the concept of empathy mean to you as a GP?
- 2) Can you specify the way you use it? How do you do it? What do you find difficult or easy? Do you feel capable of it; skilled at it? Can you give me any examples? How do you experience empathy yourself?
- 3) Does the special feature of the GP- the long-standing contact with the patient- play a role in the implementation of empathy?
- 4) There is a lot of talk about gender differences in the use of empathy. Do you have any opinion on that?
- 5) How much importance do you attach to the use of empathy in the relationship with your patients? Can you indicate this on a scale of 1 to 10? What if you relate it specifically to evidence based medicine and/or protocol medicine?
- 6) Can you give any examples of your personal experiences with empathy during the consult? Were they positive or negative?
- 7) In general, GPs are highly esteemed by their patients; if they complain about anything it is of a lack of communication skills and empathy in their GP. Do you recognize this; can you tell me anything about that?
- 8) How do you think patients experience empathy?

(C) Preconditions and barriers to empathy:

- 1) Do you think there are preconditions and barriers to being empathic? If so, what are they?
- 2) Is it possible to facilitate its use? How? Can GP training play a role in this? What was it like during your own training?
- 3) Do health insurance companies and the government show enough interest, in your opinion, to the role of empathy?
- 4) Is there enough or too much attention being paid to empathy in medical literature, during refresher courses and by professional associations? If not, how could this be improved?

(D) Final question:

We have talked at length about your views on general practice and empathy. Would you like to add anything, anything that we have not talked about but in your view is important in this context?

These were the questions I wanted to put to you. Thank you very much for replying and for your cooperation.

7

**Empathy in GP practice - the
gap between wish and reality.
A qualitative comparative
study among patients and GPs.**

**F.A.W.M. Derksen
T.C. Olde Hartman
J.M. Bensing
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**Under editorial review
of Family Practice**



"In my experience, the practice assistants sometimes tend to put themselves in the doctor's place... and they tend to be quite defensive, much more so than the doctor. Or they will ask you all sorts of questions. Sometimes I just don't want to answer them and it is not empathic at all. I think an assistant just has to accept that."

(a patient)

“I think that when I am really tired and feel like I just need to get things over with and get to the end of the day, it does show. I think I come across less empathically then, I’m too focused on myself. So feeling exhausted is clearly a barrier.”

(a GP)

Abstract**Background**

Empathy is regarded by patients and GPs as fundamental in patient-GP communication. Patients do not always experience empathy and GPs encounter circumstances which hamper applying it.

Objective

To explore why receiving and offering empathy during the encounter in GP practice does not always meet the wishes of both patients and GPs.

Method

A qualitative research method, based on focus group interviews with patients and in-depth interviews with GPs, was carried out. Within the research process iterative data collection and analysis were applied.

Results

Both patients and GPs perceive a gap between what they wish for with regard to empathy, and what they actually encounter in GP practice. Patients report on circumstances which hamper receiving empathy and GPs on circumstances offering it. Various obstacles were mentioned: (1) Circumstances related to practice organization; (2) Circumstances related to patient-GP communication or connectedness; (3) Differences between the patient's and the GP's expectations; (4) Time pressure; (5) The GP's individual capability to offer empathy.

Conclusion

When patients do not receive empathy from their GP or practice staff, they feel frustrated. This causes a gap between their expectations on the one hand and their actual experiences on the other. GPs generally want to incorporate empathy; the GP's private, professional and psychological well-being appears to be an important contributing factor in practicing empathy in daily practice. But they encounter various obstacles to offer this. It is up to GPs to take responsibility for showing practice members the importance of an appropriate empathical behaviour towards patients.

Introduction

Both patients and GPs generally regard empathy to be an important, useful and effective part of consultations in primary care. They both value a trusting doctor–patient relationship¹⁻⁶.

Patients report that consultations in which empathy is applied are more satisfactory and make them feel understood and respected. Empathy also helps them to talk freely about their worries and concerns, relieves their anxiety⁷, and decreases emotional and physical stress during consultations⁸. When patients experience a lack of empathy, they feel disappointed and sometimes even stop visiting their GP⁹. There is more and more evidence that empathy on the part of the physician is an important part of patient-physician communication, in general practice and elsewhere⁸.

GPs particularly underline that applying empathy results in them acquiring more varied important information about the patient's context. Besides, they find that empathy is indispensable in building a patient-GP relationship which is based on partnership, and that empathy helps them cope with emotional moments during the consultation¹⁰.

Patients expect their GP to show empathic behaviour to make them feel they are being taken seriously and are being supported. They want a GP to radiate humanity, equality, trust and safety. Regarding the GP's empathic skills, they want their GP to make direct eye contact and have a listening posture, and they want their GP to reflect upon earlier situations⁹. GPs generally have similar expectations of empathy in daily practice. Both patients and GPs are convinced that empathy has a positive effect on clinical outcomes^{9,10}.

Even though patients and GPs have similar wishes and expectations with regard to empathy in daily practice, there seems to be a gap between these wishes and the reality of many consultations^{9,11}. Patients often experience a lack of empathy, resulting in stressful consultations and in them feeling upset and overwhelmed⁹. GPs experience barriers in showing empathy during clinical encounters¹¹⁻¹³. So far, little research has been done into which circumstances in daily general practice create this gap between what patients and GPs want and what actually happens with regard to empathy. This qualitative comparative study explores how and why the wishes of both patients and GPs with regard to empathy in patient-GP communication, are not always met.

Method

Study design

We used data from a focus group study with patients and an in-depth interview study with GPs regarding their experiences with empathy in daily general practice (Figure 1)⁹⁻¹¹. Both studies were carried out in the Netherlands. Five semi-structured focus group interviews, with six to seven participants each, were carried out in 2015⁹. Thirty in-depth interviews were conducted with GPs between June 2012 and January 2013¹⁰.

Participants of the focus group interviews were recruited from the general population using a press report published in free local newspapers (including their websites) in four Dutch regions. Diversity in sex, age and level of education of participants was aimed at. When it turned out that women with a higher education were clearly overrepresented among the respondents, a second press report was issued, specifically inviting men and people with lower education backgrounds to take part, to try and ensure more variation within the group. This was only partly successful. Adults who had visited their GP at least once in the previous year were included. Persons who had been involved in a formal complaint procedure with a GP were excluded.

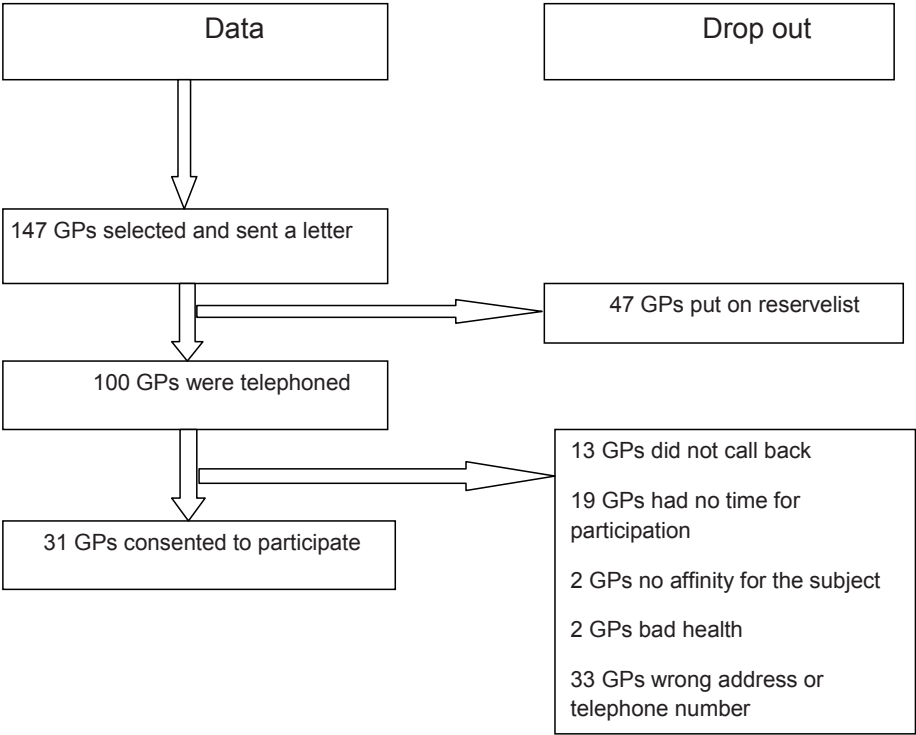
One mixed-gender group, three groups with female participants and one group with male participants were composed; one focus group consisting solely of participants with a healthcare background (as caregivers) was formed. Each focus group session was moderated by an experienced female moderator with a GP-background (LV) and audio recordings were made. The sessions lasted 90-110 minutes. More detailed information on the methodology of this focus group study can be found elsewhere⁹.

The recruitment of GP-participants was performed by a systematic random sampling from the NIVEL (Netherlands Institute for Health Services Research) GP register (which includes all practicing Dutch GPs). A maximum variation sample with characteristics such as age (<45, 45-55, >55), gender, practice type (solo, duo, or group) and grade of urbanization was reached. More details such as participants flow, further recruitment methods and GPs' characteristics can be found elsewhere^{10,11}. The interviews were held face to face at the GPs' own practices and lasted between 45 and 70 minutes. All interviews were conducted by a male experienced interviewer with a GP-background (researcher FD) who also made audio recordings and transcribed the interviews.

The focus group interviews and the in-depth interviews were based on a topic guide which was progressively adapted during the course of the interviewing process.

The study was approved by the Regional Committee for Medical Research Ethics of the region Arnhem-Nijmegen (letter dd 10-8-2015, file number: 2015-330).

Figure 1 Participants flowchart



Data analysis

Data analysis was done using a qualitative research software package, ATLAS- ti (version 7). First, two researchers (FD, ToH) selected all quotes regarding experiences of frictions or difficulties in applying empathy in patient-GP communication. The first author (FD), together with the second researcher (ToH), a male practicing GP with 10 years' experience in general practice and with expertise in qualitative research methods, categorized all quotations based on their content. During several meetings with the research team (FD, ToH, AL, JB) verbatim transcripts of the GP interviews and the patient's focus group interviews were read, analyzed and discussed. The categories were grouped into themes representing important and relevant aspects of difficult circumstances to empathy as experienced by patients and GPs during the clinical consultation. These emerging categories were discussed with the research team. Quotes which illustrate the main results were translated from Dutch into English by a near-native speaker of English and are presented here. The consolidated criteria for reporting qualitative studies (COREQ) were applied¹⁴.

Results

The study was based on five focus group discussions with a total of 28 participants, and thirty interviews with GPs. Most of the participants of the focus group discussions were highly educated and female. An overview of the background characteristics of the participants is presented in table 2⁹. The GPs' demographics show variability concerning gender, age, degree of urbanization and practice type as shown in Table 1¹¹.

We identified a number of circumstances in which patients perceived a gap between their expectations of receiving empathy and the reality of it. The participating GPs reported similar obstacles to offering empathy in the way they wanted.

Table 1: Characteristics of the 31 participating GPs

Characteristics of the 31 participating GPs	N (%)
<i>Sex</i>	
Male	14 (43)
Female	17 (56)
<i>Age</i>	
< 45 years	13 (43)
45-55 years	10 (33)
> 55 years	8 (22)
<i>Practice type</i>	
Solo	8 (26)
Duo	14 (46)
Group	9 (26)
<i>Urbanization</i>	
Rural area	12 (40)
Urban area	19 (60)
Mean experience as GP, years (range)	16 (2-33)

Table 2: characteristics of 28 participants of the study

characteristics	N (%)
<i>Gender</i>	
Male	9 (32)
Female	19 (68)
<i>Educational level</i>	
Low	0 (0)
Middle (MBO)	8 (28)
High (HBO and Univ.)	20 (72)
<i>Age categories</i>	
<50	3 (10)
50-65	13 (47)
>65	12 (43)
<i>Occupation</i>	
Education	5 (19)
Services	15 (55)
Care	7 (26)

1. Circumstances related to practice organization

Both patients and GPs indicated that the way a GP practice is organized, whether on a practical level or in communication, can be an obstacle to receiving or giving empathy in the individual consultation. However, patients mentioned different issues regarding the influence of practice organization as GPs did.

To patients, the main issues in this regard were how they often felt treated defensively and negatively by practice assistants when calling for an appointment or how they felt unduly interrogated by them.

To GPs, the most important obstacle to showing empathy in this regard was formed by unpredictable circumstances disturbing consultations, such as emergencies or incoming telephone calls.

Patients:

"It's the organization surrounding the GP that forms the obstacle; I think that generally the practice assistants tend to act much more defensively than the GPs themselves. " (FG 6-11-2015, female patient)

“When you phone, they immediately ask you why you want to visit the GP. That always gets to me, when the practice assistant asks me that... what’s it to her? In a way, I guess I understand why they ask, but it does irritate me.” (FG 24-11-2015, female patient)

“Is it so difficult for an assistant on the phone to say ‘OK, I do think the doctor should take a look at this, in spite of protocol?’ (FG 23-11-2015, male patient)

General Practitioners:

“If surgery is interrupted by an emergency, it does get more difficult, I’m aware that I’m distracted then. When the next patient comes in with a difficult problem, I can find it hard to focus on that and handle it well; I often cannot do it.” (GP, A029, male)

“Yes (sighing), it’s more difficult in the mornings than in the afternoons, because there is still so much to do, and I suddenly see that the assistant has added appointments to the schedule, because she finds it hard to say no. The result is that I’m completely overburdened. My schedule is filled with appointments and then there are all the telephone calls. It makes me feel tense and tired, and yes, it gets in the way of how I want to behave.” (GP, B073, female)

2. Circumstances related to patient-GP communication or connectedness

Both patients and GPs reported that empathic communication can be hampered when there is no feeling of connectedness or solidarity.

From the patients’ point of view, it is hard to feel connected and therefore to experience empathy, when a GP acts arrogantly, shows no real attention or authentic interest or concern, or acts irritably towards the patient. Furthermore, many patients emphasized the importance of a GPs’ non-verbal communication; when, for instance, there is little eye contact because the GP is mainly focused on the computer screen, they find it hard to experience empathy during the consultation.

A number of GPs indicated that offering empathy in patient-GP consultations can be hampered by an absence of a personal ‘click’, a lack of reciprocal interaction, or a lack of trust and openness (caused by, for instance, liability issues). They also find it hard to act with empathy towards patients who show unpleasant or amoral behaviour. Some GPs described that they are aware of the fact that prejudice can result in less empathic behaviour.

Patients:

“I really experienced arrogance then. I have an education background, so I know how it should be done; I really felt treated like a child.” (FG 24-11-2015, female patient)

"I am brain-damaged, my memory doesn't work that well, and that caused the friction. She felt that I kept repeating myself, but I simply wasn't aware that I had told her this before. I could really feel her irritation." (FG 10-11-2015, female patient)

"He'll be sitting there behind his computer. There's no eye contact, you can't see how he feels about what you're telling him." (FG 6-11-2015, male patient)

"The first thing that springs to mind is listening with interest. To me, listening is of the utmost importance, and especially that you feel that it's genuine. That the other person really wants to know how you are. Not some professional attitude, but authentic interest." (FG 10-11-2015, female patient)

General Practitioners:

"That can really make me lose my empathic capabilities, when people are very aggressive or distrustful, like 'the GP will just try and get rid of me by giving me some paracetamol'. When I perceive an attitude like that, it can really influence my behaviour." (GP, B057, female)

"If there is a legal undertone, or when someone is just very angry, it makes it hard for me to act with empathy. It can certainly make me hold back." (GP, B071, female)

"It's quite clear to me: if I really dislike someone, it is very difficult for me to be empathic. On the other hand, when you really do like someone, there's a risk of getting too involved, of doing too much. There is a possibility that you don't do enough for someone that you have a difficult relationship with, and I don't want that. And those you do like, you may spend too much time and energy on them, at the cost of the others." (GP, A 007, male.)

3. Differences between the patient's and the GP's expectations

Patients and GPs, when speaking about consultations in which a lack of empathy is perceived (by one or both parties), described how differing expectations of the consultation can play a part. Patients expect their GP to pay attention to the patient's environment, opinions and expectations; to create an atmosphere where the patient can speak freely, to create common ground and to try to involve the patient in making decisions. When these expectations are not met, patients feel let down and a lack of trust can be the result.

Some of the GPs in this study indicated that they experienced difficulties in meeting the patients' expectations because of the influence of protocols and checklists. Furthermore, some GPs also mentioned that personal preconceptions play a role in not fulfilling patients' expectations.

Patients:

"He will be standing next to his desk, and it's obviously over, so I'll just go. He does address the problem, but he will never just ask how I am, not even when I haven't seen him for a long time." (FG 10-11-2015, female patient)

"To me, not being involved by a GP in decisions that are taken, decisions that affect the client, that's the most serious lack of empathy. To me, that's shocking." (FG 6-11-2015, male patient)

General Practitioners:

"With diabetes-sufferers, for instance, we have to record about 73 items in a list as part of integrated care, and I thoroughly dislike that, because you're spending most of your time looking at the computer screen instead of at the patient. What you really want is spend time on the problem that patient is actually there for." (GP, A004, male)

"In my experience, the more you're doing your own thing, the less you really listen. That way you run the risk of missing things in a patient and later you think, if I had just kept quiet for a moment and listened, if I had just taken a little bit more time, I would have picked up on things that would have changed the situation and the patient would have been more satisfied." (GP, A 007, male)

4. Time pressure

Many patients stressed how essential it is to them for a GP to give them time and space in order to be able to experience empathy. In reality however, they often experience a lack of these aspects during or around the consultation.

Many of GPs addressed time pressure as an important hampering factor in offering empathy. Examples of this they mentioned were overloaded work schedules, full waiting rooms and red tape.

Patients:

"There are GPs who, the moment you say you have some psychological issues, get flustered and start looking at their watches; they obviously find it difficult to listen." (FG 23-11-2015, male patient)

"A GP consultation, those 10 minutes are over before you know it. It feels like they listen to you, but don't really step into your shoes. Time is certainly an issue." (FG 6-11-2015, male patient)

"You want to feel like there is enough time, that there is room for you. Also, that there is enough time for some open questions at the end of the consultation; that the GP can ask you whether you have any questions, for instance." (FG 10-11-2015, male patient)

General Practitioners:

"Time. Bringing up a whole new set of issues, while you simply don't have the time, and the waiting room is full, I feel no shame in saying that I simply don't want to do that; I must get on." (GP, A010, male)

"Sometimes it's just a matter of racing on. And when you are with a palliative patient, and there are all these other things you have to do, it can be very difficult to actually take the time to act empathically." (GP, A051, female)

5. The GP's individual capability to offer empathy

Some GPs indicated that applying empathy during the consultation is difficult for them when their personal capability to offer empathy is limited. This can occur when their physical condition is not good (feeling ill or exhausted) or when they are distracted by private issues. One or two participants of the focus group interviews mentioned how patients' expectations of the GP's capacity to offer empathy at any moment may at times be too high: *"I think that at times we expect too much, and maybe our demands are too high. They're only human (FG 24-11-2015, female patient)"*.

General Practitioners:

"I was definitely less empathic then, because I was so tired, and I was in a bad mood and snappy; I was simply exhausted and that absolutely affects the way I work with my patients." (GP, B003, male)

“Having a stressful morning, having to take my daughter to the sitter, being late, not having enough time to take care of myself, brushing my teeth in a hurry, and the washing-up is still in the sink, yes, they are all factors that do not have a positive impact on empathy.” (GP, B057, female)

“I’m about to go on holiday, and last week I really decided to I have to put the brake on things until then, like from now up to Friday, things just have to go to plan, some things just have to get done, people have to be left behind well. But that can only happen when I don’t have to deal with an additional 5 major issues every day. There are limits. So I have to limit my empathy a bit. There is no endless source of empathy inside me that can keep on being tapped.” (GP, B071, female)

Discussion

Summary

Even though both patients and GPs regard empathy as crucial in patient-GP communication, there exists a clear gap between wish and reality. Receiving empathy by patients and offering empathy by GPs is hampered in several ways, from the behaviour of the reception staff, the GP not having enough time, or not showing authentic interest and concern, to a lack of eye contact during the consultation (an essential non-verbal empathic skill) or the GP being distracted by organizational or personal issues. Patients emphasized how unfriendly and non-empathic reception staff can make them feel unwelcome. Both patients and GPs see the bureaucratic overload and obligatory checklists that GPs are sometimes faced with as negative influences on GPs’ empathic behaviour. All these circumstances stand in the way of the patient’s expectations of being given room to speak freely, of creating common ground and of being involved in making decisions. Apart from these more external factors, GPs also mentioned internal ones: they only have a limited amount of empathy to give, and this amount can be affected by personal circumstances.

Additionally, both GPs and patients indicate that some kind of personal bond or connectedness is a prerequisite for an empathic patient-GP relationship.

Comparison with existing literature

The purpose of this study is to explore elements in patient-GP communication which result in unfulfilled wishes of patients and GPs with regard to empathy. The results provide a more detailed insight into as yet underresearched aspects of how empathy in patient-GP communication is offered and perceived.

An important obstacle in experiencing and applying empathy, according to patients as well as GPs, appears to be the daily practice organization. Participants of the focus group interviews

particularly mentioned non-empathic behaviour by reception staff – mostly related to their current triage task - as a cause for irritation. This finding is in line with the outcome of a study in primary care in the UK in which the helpfulness of the reception staff turns out to be the second most important factor of patients' overall satisfaction¹⁵. The role of the reception staff has been confirmed by another study in primary care which shows that patients in some Western European countries experience the existing triage system in some countries (UK and the Netherlands) as helpful to the receptionist rather than to the patient¹⁶. When a friendly reception staff exists, patients' coping strategies are enhanced¹⁷. Research in a hospital setting shows that an empathic staff is related to fewer repeat visits and increased satisfaction of patients with received care¹⁸.

The GP's private, professional and psychological well-being appears to be an important contributing factor in practicing empathy in daily practice. GPs acknowledge this and some of the focus group participants recognize it and brought it up spontaneously during the discussions. Since it has already been found that many GPs are at risk of burnout^{19,20}, it is important for GPs to recognize the power of the emotional and physical challenges they face during practice. Participating in regular supportive supervision with colleagues and peer-support can be important preventive measures¹⁹. Participating in inter-collegial counseling (Intervision courses and Balint groups), guided by a behavioural counselor, lessens professional isolation, enhances GPs' morale, increases sensitivity to patients and decreases the incidence of burnout²¹.

Strengths and limitations

An important characteristic of this qualitative study lies firstly in the comparison of both the experiences of patients and GPs, and secondly in its basis in daily primary care. To the authors' knowledge, this is the first qualitative comparative study focusing on empathy in patient-GP communication specifically²². Patients and GPs were invited to share their stories and opinions and to express themselves freely. This reveals valuable insights into personal elements of the affective side of communication in GP practice. The data of the focus group interviews and of the GP-interviews complement each other in many aspects. Tape-recording the GP-interviews and focus group interviews, evaluating and checking the participants' contributions at the end of each interview and multiple coding during the analysis add to the rigor of the study.

The data collected through the focus group interviews lack narratives of male and lower educated participants. The research team actively tried to redress this imbalance, but did not fully succeed.

It is possible that patients not accessed by the study have a different view of empathy than the slightly older, mostly female, middle class participants who took part.

Moreover, it is acknowledged that voluntary participation, both of patients and GPs, may have caused selection bias with participants with little interest in empathy being underrepresented. Furthermore, with the moderator, focus group observer and analyzers all having a GP-background, our interpretation of the data from the focus group interviews might be slightly biased. However, we are convinced that by including a behavioural scientist in the supervising committee (JB), this potential bias has been sufficiently redressed.

Qualitative studies are limited in their generalizability. However, compared with quantitative studies, they can provide richer insights. It is possible that, due to the design of the current study, the transferability of the results presented in this study is limited and deserves further investigation; one should be careful to generalize the results.

Implications for practice, education and further research

The importance of self-care for physicians has been highlighted²³. In addition, there is an awareness of the advantages of continuous intercollegial counseling with GPs, such as: a valuable opportunity to pay attention to personal and emotional growth; the possibility to increase competency and well-being and a reduction of burnout²⁴. Primary care institutions should support organizing continuous coaching (intercollegial counseling, supervision, Balint groups) and mindfulness sessions. Branch has provided a practical approach to this²⁵.

Attention to patients' expectations and evaluations of communicative aspects are instructive²⁴⁻²⁸, and closely matched beliefs of patients and care-providers produce higher levels of satisfaction and trust²⁹. We advocate to improve GPs' knowledge and skill, during postgraduate courses, about how to cope with patients' expectations and how to encourage patients' self-disclosure^{27,30-32}.

So far, there is not enough explicit attention to empathy in patient-GP communication during GP education²⁴. The same is true for vocational training of practice assistants. We recommend a tailor-made vocational training programme for GPs and practice assistants.

The results of the current study become more useful when there is additional data from both observational research of the actual behaviour of GPs and reception staff.

It may seem a lot to ask to apply the above-mentioned suggestions in the hectic reality of daily primary care. To help GPs it is necessary for primary care institutions - the GP-association and the association of practice assistants - to provide structural support.

Conclusions

This study shows that within patient-GP communication perceiving a 'click' with someone and experiencing empathy are more or less congruent. Not receiving empathy from a GP or his/her reception staff can be very unpleasant and frustrating for patients and causes a gap between their expectations on the one hand and their actual experiences on the other. GPs

notice that a personal limited physical and mental ability to offer empathy influences their behaviour. Furthermore this study indicates that it is up to GPs to take responsibility for showing all practice members the importance of an appropriate and empathical behaviour towards patients. In addition primary care institutions - the GP-association and the association of practice assistants – should provide structural support, within this framework, to workers in GP practice.

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Conflict of interest

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8

General discussion



“Her behaviour towards me gave room to my own feelings, and that was kind of confrontational at first... your own feelings. But it allowed me to think about what I really wanted and that turned everything around; it made me try and develop a positive attitude, to take back control, based on my own feelings.”

(a patient)

“Can I cry or shouldn’t I; should I go to the funeral of that patient or not.

There is a boundary and I can work with that. I think it’s okay to have emotions, as a GP it’s okay to show you have feelings and you’re not a businesslike person, but there is a boundary and that is your professionalism.”

(a GP)

Introduction

This thesis aims at providing insight into the characteristics and dynamics of empathy in patient-GP communication in daily practice. It looks at the effectiveness of empathy and at the differences between patients' and GP' expectations regarding empathy. Patients' experiences and opinions are described. Furthermore, GPs' experiences with obstructing and facilitating factors in delivering empathy in daily practice are described. GPs' and patients' perspectives have so far been relatively underexposed in research literature. In this final chapter we will set out our main findings as well as the methodological strengths and limitations of this study. We will also address the implications of this study for general practice and GP education, as well as suggestions for further research.

Main findings

In **Chapter 3** we performed a literature review, focusing on empirical research into the effectiveness of empathy in general practice. We found a significant correlation between GP empathy and patient satisfaction. It has been demonstrated that GP empathy has a relationship with higher patient enablement, reduction of patients' anxiety and distress, improvement of somatic outcome parameters (e.g. HbA1c and LDL-cholesterol), and less severe and long-lasting symptoms of common cold. Whenever GP empathy is applied GPs get more extensive information about the patient's condition (e.g. psychological and social issues).

To explore how patients experience empathy in the patient-GP encounter and to get an insider's view we conducted a qualitative study based on in-depth focus group interviews (**Chapter 4**). These clearly showed that patients are very aware of the impact of empathy in the patient-GP encounter. Nearly all the participants stated that a GP's empathic behaviour results in satisfying consultations. Some patients described how it enhances their coping behaviour and sense of enablement. Participants indicated that a lack of empathy can result in stressful consultations and in avoiding contact with the GP. According to patients, a lack of empathy can be an obstacle to receiving adequate primary care. Sharing too much private information and increased anxiety about their condition were mentioned as potential negative side effects of GP empathy.

In order to identify GPs' experiences and views, we conducted in-depth interviews with GPs (**Chapters 5 and 6**). **Chapter 5** focuses on how GPs assess and accomplish empathy. The participating GPs regard empathy as an important element of the consultation. They generally assessed empathy as an opportunity to recognize patients as equal human beings. They mentioned imagining the thoughts and feelings of patients and their receptivity as characteristics of their empathic behaviour. Non-verbal aspects of empathic communication (e.g. having an interested facial expression, keeping eye contact and using actively

interested body language) were considered to be essential. In addition, GPs described verbal aspects such as being alert to cues and reacting to them, and referring to previous consults or life events. According to the GPs, being genuine and respectful, cultivating a good atmosphere and showing feelings of equality are fundamental aspects of empathic behaviour. An efficient practice organization (e.g. not being disturbed by practice assistants or incoming telephone calls) and the absence of time pressure were mentioned as important prerequisites for empathic consultations, as were physical fitness and being free of private worries. **Chapter 6** describes what barriers GPs encounter in applying empathy and how they manage these barriers. Protocol-driven care, with its guidelines, obligatory questioning and bureaucratic requirements, was mentioned as an important potential barrier for GPs to remain genuinely person-oriented during the consultation. GPs indicated that they sometimes deviate from the recommendations given in the guidelines in order to preserve a patient-as-person approach. Another potential barrier GPs mentioned is the tension between being emotionally involved and keeping a professional distance.

Since both patients and GPs indicated that their wishes to receive and to provide empathy are not always fulfilled, **Chapter 7** explores the differences in the expectations and experiences of both groups, using a comparative qualitative analysis. We identified several circumstances that make it difficult or impossible to fulfill patients' and GPs' expectations. Among the circumstances that patients identified, are not having sufficient consultation time, the GP not showing enough authentic interest and concern, a lack of eye contact during the consultation, the GP being distracted by organizational or personal issues and unwelcoming behaviour of the reception staff. In addition, both GPs and patients indicated that there needs to be some kind of personal bond or connectedness for an empathic patient-GP relationship to grow. GPs expressed that feeling tired or going through private problems can make them act less empathically than they would want. Furthermore, they indicated that there is a limit to their ability to offer empathy during the patient-GP encounter.

Discussion of the most important themes

Reflections on the concept of empathy

Empathy can be regarded as a multi-faceted catch-all concept. Scientists such as e.g. behavioural scientists, sociologists and psychologists have found it hard to agree on a definition of empathy. Some think of empathy as emerging from mostly *cognitive* mechanisms, including emphasizing, perspective-taking and related 'theory of mind', which involves imagining the other's point of view or internal experience^{1,2}. Other scientists think of it as a more *affective* process, experiencing and sharing another person's psychological and emotional state^{1,3}. This affective process includes emotion-matching with others and concern for others' suffering^{1,3}. Still other theorists see the emotional and cognitive aspects of

empathy as overlapping rather than separate⁴. Studies have found that among individuals with an antisocial personality, the cognitive factor of empathy is preserved while the affective component is impaired. Individuals with antisocial personalities perform similarly on perspective-taking tasks compared to healthy individuals, but show weaker emotional responses when confronted with someone in distress^{1,5}. Some scientists have made a distinction between 'trait' empathy versus 'situational' empathy: people scoring high in trait empathy often have a chronic tendency to respond empathically, whereas situational empathy is induced only by certain situations^{1,3}. In addition to the concept of empathy as a character trait, some scientists see empathy as specifically originating in the parent-infant dyad^{6,7}. In sum, empathy, in a scientific context, is a widely used complex concept, on whose definition and application there is no real consensus.

Philosophers, among whom Paul Ricoeur (1913-2005), have tried to shed some light on the issue. According to Ricoeur, it all starts with the question: "Who am I?". In trying to answer this question, communication with another person is necessary, and to see oneself as another is related to seeing the other as oneself. Being concerned about ourselves, almost necessarily implies being concerned about others. Respect for the other and for the self, as well as an acceptance of being imperfect, feel like moral imperatives which should guide our behaviour. Looking another person in the eye, giving them a name and recognizing their individuality, are essential building stones of human relationships. According to Ricoeur fundamental vulnerability and relationality are distinctive features of human existence and are inextricably bound up with our moral sense of self⁸⁻¹¹.

With regard to medical literature scientists have also tried to find a precise definition of empathy as a desired underlying attitude of physicians^{12,13}. One of the mostly used definitions is that of Mercer and Reynolds¹⁴. Several elements of empathy, as been mentioned above, are discussed in this definition and medical literature as well: an emotional state as a necessary part of the moral behaviour of a physician, cognitive and affective elements, verbal and non-verbal skills and an internal altruistic personal characteristic^{12,14,15}. In the clinical context empathy is regarded as a prerequisite for getting necessary information, for understanding relevant symptoms, for a good patient-GP relationship and for recognizing the patient as a human being¹⁵. Moreover, there has been much discussion about whether a physician is actually able to feel what the patient feels at any time and about how much parallelism between a physician and patient is necessary^{15,16}.

Little has been published about empathy in Dutch primary care-related literature during the past 20 years. Van den Hoofdakker, in 2002, tried to construct a definition of empathy by describing the thought processes of the health care provider. Speaking from his experience as a caregiver, Van den Hoofdakker divides empathy into different components, e.g. a

caregiver's empathic *attitude* and their empathic *competency*¹⁷. This seems to be a useful manner to describe the various aspects of empathy during the consultation.

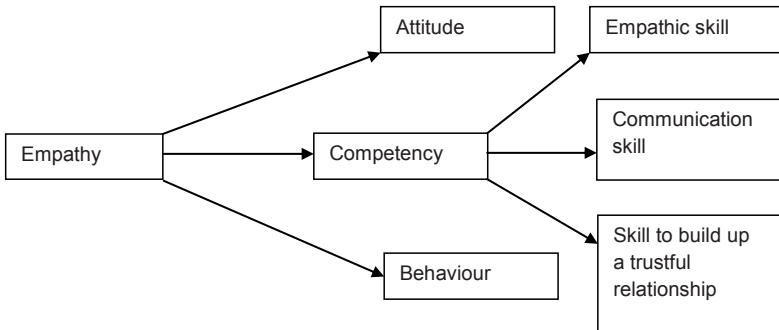
Focusing on the GP as empathy giver, we therefore distinguish empathy at three levels: as an *attitude* (an adequate inner affective characteristic of the physician)¹⁸⁻²³, as a *competency* (a cognitive capacity)^{20,24-29}, and as a *behaviour* (the active side of care)^{18-21,24,27,30,31}. (figure 1). The combination of these three aspects allows empathy to play its full part in the GP consulting room.

Attitude is based on moral standards of the physician and is regarded to be an internally motivating force. GPs in this study, when speaking about this aspect, discussed qualities such as being receptive and authentic, being patient-oriented, and being respectful and interested. Patient participants of our focus group interviews mentioned similar qualities as basic empathetic traits of a GP.

Competency, as a necessary skill in order to perceive and treat a patient as an individual person, can be subdivided into empathic skills, communication skills, and skills to build a relationship with a patient. Many GPs in this study highlighted recognizing and appreciating patients as human beings as an essential empathic skill; similarly, many patients expressed how important it is to them to feel taken seriously. Listening to, understanding and reflecting on patients' thoughts and feelings are seen by many of the interviewed GPs as important communicative skills. Only one or two of them mentioned that empathy plays a role in building up a trusting and long-standing patient–GP relationship. Yet, on the other hand patients in this thesis underlined that receiving empathy has to do with feeling welcome and at ease which is reciprocally ascertained by the existence of an open and personal relationship.

Empathy as *behaviour* has both cognitive and affective aspects. The cognitive part includes verbal and/or non-verbal skills and the affective part includes the recognition of the emotional state of the patient. Non-verbal behaviour is estimated to account for 60-90% of communication³². In our study a number of GPs mentioned showing empathy and recognizing the patient's emotional state as an important aspect. They also discussed the importance of different non-verbal techniques such as an interested facial expression; keeping eye contact; leaning backward or forward; and physical contact like a hand on the patient's shoulder. A recent systematic review indicates that, to patients, non-verbal expressions of empathy are essential components of quality of care³². Discussing verbal skills, GPs in our study talked about things like a relaxed tone of voice; pauses; interested listening; clarifying; summarizing; and reflecting on patients' cues. Strikingly, patients in the focus group interviews did not focus specifically on this issue. Their emphasis was on feeling safety, trust and support; feelings that the GPs hardly mentioned.

Figure 1. Subdivisions of empathy.



There seem, then, to be few differences in opinion about empathic *attitude* and *competency* between patients and GPs. With regard to empathic *behaviour*, there do seem to be some slight differences, especially about the affective part of it. To interpret these differences, developments in communication in general, e.g. an increased individualism in Western society, as well as other aspects, should be considered^{11,33-35}.

Patients' perspectives

Patients' experiences with empathy and the triage system

As is shown in this study, patients are not occupied with definitions, conceptual aspects and guiding principles of empathy³⁶⁻³⁸. They are, however, quite aware of the circumstances that influence the position of empathy in general practice.

Patients consider communication with their GP and the reception staff to be the most important drivers of their overall satisfaction with care in general practice; friendly and helpful reception staff also enhances their coping strategies^{39,40}. Discussing their experiences with empathy in general practice, patients in this study confirm the vital importance of empathic behaviour of the reception staff. They see the reception staff as the 'frontline', in that speaking to practice assistants on the telephone is their first opportunity to confer about their problem. They view the practice assistant as an 'extension piece' of the GP and expect there to be good cooperation between the GP and the rest of the practice staff. They expect practice assistants to show openness and empathy during the telephone conversation, and are severely disappointed when they are instead met with what they perceive to be defensive and discouraging questions. This happens particularly when the practice assistant goes through a long checklist. They often experience the assistant as obstructing access to the

GP. Both these issues, the practice assistant 'protecting' the GP and practice assistants asking too many questions, are regarded by patients as disturbing and as a sign of a lack of empathy. This reduces their sense of being able to communicate freely with the general practice.

These negative experiences show that, in fact, patients in this study are often negative about the current triage system in daily general practice. A standardized triage system was originally introduced in the Netherlands to streamline the accessibility of out-of-hours primary care in the general practice cooperatives⁴¹. Trained nurses execute triage by means of a standardized six level triage system (the Netherlands Triage System, NTS) and decide what type of consultation the patient requires⁴². More recently, this concept was introduced into daily general practice, again with the aim of streamlining accessibility.

Earlier studies found similar patients' experiences and views on this issue as we did in our study. Long et al. found that patients do not want to explain to receptionists why they want to see their GP. They want more sensitive receptionists and fewer prying questions when seeking access to the GP⁴⁰. Specifically in the Netherlands, people expressed feeling uncomfortable about these questions⁴³. The GULIVER study, a study about patients' experiences and wishes in a number of Western European countries, shows that patients have clear ideas about what they consider to be good accessibility to the GP and how they regard the receptionist 'as a filter'. When patients have new health problems, they find it particularly important to have direct access to the doctor without interference by a practice nurse or receptionist. In countries with a functioning triage system especially (UK and the Netherlands), the lack of direct access to the GP led to many critical comments^{44,45}.

Evaluating the research into the suitability of the triage system in daily general practice, it is clear that there are still questions to be answered: whether the benefits of the triage system in general practice outweigh its drawbacks⁴⁴, and whether the suitability of new methods such as the triage system was sufficiently evaluated before these methods were applied generally⁴⁶.

GPs in this study emphasize that the possibility to spend more time with certain patients is an important precondition and facilitating factor for empathic behaviour. In order to decide which patients need more consultation time, they find that efficient telephonic triage by reception staff is necessary. It is obvious that there is conflict between what GPs think about this issue and what patients want. Considering that easy accessibility to GPs is a cornerstone of primary care, our findings suggest that GPs and other stakeholders should reconsider the appropriateness of the current triage system, as well as the manner in which practice workers communicate with patients in general. Naturally, patients' experiences and expectations should be at the heart of such a reconsideration⁴⁷.

The triangle of empathy, trust and enablement

The Can MEDS physician competency framework and the American Institute of Medicine promote that physicians - in their role of communicators and using trust, shared decision-making and empathy - should effectively facilitate the doctor-patient relationship⁴⁸⁻⁵⁰.

Patients in our study indicate that a GP's empathy has a pronounced effect on their feelings of safety, of being supported and of trust. It is noteworthy that they strongly appreciate these feelings and moreover that they associate them with being assisted in developing adequate coping strategies to take control of their own situation.

Recently, Mercer et al. found that enablement – the extent to which a patient, after a medical consultation, feels to be able to cope with, understand and manage his/her illness - does not occur when the patient perceives low levels of empathy in the doctor. Therefore, they state that the patient's perception of GP empathy is of key importance in patient enablement in general practice consultations in both high and low deprivation settings⁵¹. In addition, general practice and its long-term patient-GP relationships themselves are regarded as circumstances which work as important catalytic agents to identify patients' strengths^{52,53}.

Empathy especially helps the GP to reach the patient in his/her illness and to value the patient as a person^{28,54}. This in its turn increases the patient's sense of trust, self-control and of being known⁵⁴, and activates their development of adequate coping strategies⁵⁵. The experiences of patients as described in this thesis elucidate and confirm these findings.

Elaborating on this theme it can be hypothesized that a triangle between *empathy, trust and enablement* exists in consultations in general practice. This correlation has been discussed in academic literature from different points of view.

Firstly, in their research into the characteristics of GP communication, De Haes and Bensing, in a conceptual model of medical communication, identify 'fostering the relationship' as a first and necessary communication goal. They argue that without trust in a care-provider, none of the other goals of medical communication, e.g. gathering and providing information or decision making, can be pursued optimally⁵⁶. Trust can be considered as the collaborative and affective bond between patient and GP⁵⁷. The quality of the relationship (consisting of factors such as the manner of communication and a GP's knowledge of a patient and their background) is a particularly important factor in the patient's trust in the GP⁵⁸.

Secondly, Fugelli starts from 'personal doctoring'. With that he means: trying to create a meeting what Martin Buber calls 'an I and a You'⁵⁹. Fugelli stated: "A patient is a fellow human being whom we should approach with humility, respect and non-dominance; the GP realises that there is only one expert on the patient's feelings and bodily sensations – the patient him/herself. So cooperation and sharing power is obvious." According to Fugelli trust is facilitated by personal doctoring and by sharing power with the patient. He goes on: "If personal doctoring and sharing of power are done in a cold and calculating manner then trust

may fade away. To suffer with, to convey empathy for the patient's distress, to show concern for his or her good promotes trust."⁶⁰

Thirdly, the salutogenetic perspective is based on the premise of a patients' strengths and underpins the importance of acknowledging the patient as a person who is able to manage the situation him/herself, and of a mutual engagement of professionals and patients in a process⁶¹.

Both patients and theorists seem to consider empathy to be embedded in other concepts such as trust and enablement. Generally speaking, supporting and improving practitioner empathy may be crucial in enhancing patient enablement.

General Practitioners' perspectives

GPs' experiences with empathy and clinical guidelines

GPs in this study consider empathy to be an important and quality-increasing characteristic of daily consultations. At the same time GPs indicate that empathy can be hampered by various barriers. The barrier that GPs in our study mentioned most of all, is the impact of clinical guidelines and protocols on GPs' empathic behaviour. The daily work of Dutch GPs is heavily influenced by the standards set by the NHG (Dutch General Practitioners Society) and by protocols based on those standards. These standards, originally designed to make the work of GPs verifiable, can arguably be seen as one of the most important factors that have improved GP care^{62,63}. Over a hundred standardized guidelines are used in general practice⁶⁴. These guidelines are mostly developed using evidence-based knowledge. They are considered to bring GPs safety and support in diagnosing and treating patients in an optimally evidence-based manner. In addition, they support GPs because they are ratified by professional organisations and can therefore protect GPs against malpractice litigations^{36,65,66}.

Judging the usefulness of clinical guidelines, Butalid et al. found that the implementation of certain clinical guidelines, for instance regarding hypertension, resulted in high ratings by GPs and lay people of the quality of doctor-patient communication. Butalid et al. suggest that a more routine approach in daily practice is appreciated by both doctors and lay people⁶². On the other hand, GPs' adherence to guidelines seems to be on the decline because they experience its dominating position as resulting in a lack of attention to personalized care⁶⁷⁻⁷¹. Vanheule discussed the DSM-5 in terms of a pressing attention to "checklist" diagnostics⁷². The guidelines and their protocols are mostly somatically oriented and it can be hypothesized that the current emphasis on task-oriented communication may partly originate from the ever-expanding numbers of standardized guidelines⁶². In recent years health insurance companies have focussed on the GP guidelines – in order to define quality of care indicators for care in general practice.

GPs in this study show concern about the role of guidelines and protocols. Questioning protocols are regarded by many of them as 'straitjackets', forcing them to focus mainly on bio-medical aspects of care. They feel less connected to the patient and less able to be genuinely person-oriented during consultations. They feel less involved with the patient's emotions and pay less attention to seemingly casual remarks made by patients, even though they are aware of the importance of such 'cues'. These experiences are in line with the results of an earlier observational study⁷³. GPs put forward that, in order to deliver high quality personalized care, it is necessary to be flexible and to deviate from the recommendations described in the guidelines in order to search for a balance between following guideline requirements and being empathically interested. Van Os et al. have also pointed out that simply following guidelines is not enough to deliver good quality care. The best outcomes for patients will be reached when doctors follow the professional guidelines and at the same time have the ability to build a trustful and personal doctor-patient relationship with their patients⁶⁷.

Greenhalgh et al. recently reintroduced empathy as an important factor in a renewed approach of evidence based medicine. They argue that evidence-based medicine should reintroduce its founding principles, i.e. a strong interpersonal, humanistic and professional relationship, empathetic listening and a collaboration between an expert physician and an expert patient⁷⁴.

Balancing emotional involvement and professional distance: the thin line between job satisfaction and burnout

Patient-physician communication, by its nature, can result in the physician sharing the patient's emotions. Several GPs in this study brought up the fact that in trying to approach patients in a humane and personal manner, they encounter difficulties in balancing empathic behaviour and professional distance. They reported that over-identifying with a patient's distress and becoming overwhelmed by the patient's suffering can hamper taking the right professional decisions.

Not many studies have examined how 'situational empathizing' affects the empathizers themselves^{1,15,75-77}. The little evidence there is, shows that these effects move between two extremes. At the one extreme, physicians can react in a very detached manner. Roger Neighbour has described this in the following words: "*Sooner or later – and it is often while at medical school – all doctors experience situations that are unforgettably shocking or traumatic. Many of us respond self-protectively by detaching our human responses in order to cope. It is as if a switch is thrown, disconnecting our clinical skills from our emotional intelligence*". This blocking of engagement with the patient's, and thereby their own, emotions can have a negative effect on doctors as *persons* by increasing stress and anxiety and

making them more prone to emotional burnout. It also can negatively affect doctors as *professionals*, in that they supply inappropriate and ineffective care⁷⁶. This detached reaction can result in defensive coping styles and in feelings of vulnerability being buried⁷⁸. At the other extreme, over-identifying with a patient can result in the doctor mixing up empathy with sympathy. One could say that sympathy involves a feeling of sharing the pain and suffering of the other, whereas empathy involves an effort to understand the patient's experiences without sharing them^{15,79}. This is an important issue, since being too sympathetic can lead to compassion fatigue and ineffective care⁸⁰. Moreover, sympathy can emerge from a selfish motivation to alleviate the physician's personal distress^{81,82}.

Applying effective empathy can lead to a disturbance of a GP's emotional balance and positive frame of mind. Caring can be stressful, difficult and emotionally draining and concern for others can sometimes keep caregivers from taking care of themselves. GPs in our study indicated that there are limits to their ability to cope with the combination of daily practice and their private situation. They reported that aspects such as personal circumstances or their physical condition affect GP empathy. Feeling tired, going through stressful private situations, or being distracted by practicalities can have a negative influence on empathy in patient-GP consultations. Strikingly though, none of the interviewees put forward that empathy causes an emotional burden, even when specifically asked about it. On the contrary, GPs stated that higher job satisfaction, protection against burnout and frustration, and experiencing positive energy are important positive side effects of using empathy. Studies among GPs suggest a direct relationship between empathy, empathic listening and burnout⁸³⁻⁸⁶. At the same time, however, applying empathy can be an aid in protecting people in caring professions against burnout and can play a part in a search for a balance between involvement and professionalism⁸⁷⁻⁹⁰. Other studies confirm the findings of this study, that using empathy makes GPs more satisfied with their job, especially when patients show gratitude or appreciation for it^{15,91-95}. This positive link is underlined by Halpern when she, in her influential work, presents empathy as the ideal skill to find a balance between emotional overinvolvement and detachment; she considers empathy as supporting caregivers to find meaning in their professional activities and to become aware of their own feelings and abilities^{96,97}. This self-knowledge allows one to have a controlled, balanced and efficient regulatory process of empathy-related responding and to maintain a clear self-other separation^{15,98,99}.

GPs in our study regard participating in intercollegial counseling (Balint-courses) as beneficial in balancing involvement and professionalism. In their opinion, this opportunity to reflect on their work experiences with other professionals gives them support and provides insight into their roles, skills and emotional balance. They stress that this kind of intervention should have recognized certification.

Limitations and strengths

Although important limitations and strengths of this study have been discussed in detail in the relevant chapters, we wish here to specifically discuss some of them. Voluntary participation, both of patients (as a result of a press report in local news papers) and GPs (as a result of an invitation letter), may have caused selection bias with low representation of participants with little interest in empathy. Underexposure of negative thoughts on empathy is therefore a possibility.

The fact that the main researcher used to be a GP, may have affected data collection during the GP interviews. This 'shared' background may have led to a lack of objectivity on the interviewer's part, and to participants giving socially desirable answers. The qualitative data collected through the focus group interviews lack narratives of lower educated male participants, and focus group interviews, by their nature, can lead to participants making socially desired comments.

However, the potential negative effects on the GP-interviews were limited as much as possible by using an interview guide, based on literature and expert opinions. Furthermore, the experienced moderator of the focus group sessions has paid special attention to preventing socially desired answers being given. And indeed it is possible that patients who were not accessed by this study view empathy differently from the slightly older, mostly female, middle class participants who took part.

Qualitative studies are always limited in their generalizability, and one should therefore be careful in drawing general conclusions from this study as well; the results deserve further investigation and their transferability is limited. Nevertheless, we are convinced that the qualitative method is appropriate to explore and clarify GPs' and patients' opinions, as, compared with quantitative studies, a qualitative study can provide much richer insights into patients' and GPs' views.

Notwithstanding the fact that the moderator, the focus group observer and the analysers almost all have a GP-background, we do not think that our interpretation of the data is biased, as a behavioural scientist was involved in the supervising committee (JB) and contributed to the process of analysis of the data.

Major over-all strengths of this study are its founding in general practice and the robustness and trustworthiness of the qualitative methods applied^{100,101}. Tape-recording the discussions, evaluating and checking the participants' contributions at the end of each session and multiple coding during the analysis added to the rigor of the study. Through the qualitative method, focus group discussions allowed participants to share their stories and opinions and to express themselves freely. This revealed valuable insights into person-centred elements of the affective side of communication in general practice. The in-depth interviews with GPs have delivered a picture of their personal opinions about empathy, their subjective

interpretations of empathy, barriers to empathetic behaviour and how they manage these barriers, which is a significant and hitherto under-researched aspect of daily general practice. Moreover, the fact that we have once more underlined the relationship of empathy in patient-GP communication with psychological and physical outcomes – in the shape of a literature review – can be regarded to be a strength of this thesis.

Future perspectives

Implications for future research

Results of mixed-method research by associating results of qualitative, quantitative and observational studies of the actual behaviour of GPs and reception staff, are likely to draw more attention of GPs and GP-organizations and should therefore be promoted¹⁰².

Both patients and GPs in our study describe the important role policymakers and health insurance companies can play in protecting and stimulating the position of empathy in patient-GP communication. A number of the interviewed GPs underlined that empathic listening takes time, but they are also aware of the fact that this investment in time is very effective. Recently, health insurance companies and Dutch GPs has made some agreements (e.g. less bureaucracy)¹⁰³.

However, it remains interesting and inspiring to conduct a study about the view of health insurance companies on the barriers GPs experience and on their opinions about pay for performance (e.g. “kijk en luistergeld”). The need for spending more time with the patient as necessary precondition for GP’s empathy and the impact of financial incentives on this time-consuming aspect has been highlighted by Neumann *et al.*^{30,104}.

The qualitative research of our study should be followed up by further examination of how measuring empathy can be practically implemented in general practice and vocational GP education. A validated empathy measure such as the Consultation and Relational Empathy (CARE) should be applied¹⁰⁵⁻¹¹⁰.

Although the results should be looked at with some reservation, a number of American and British studies suggest that medical students’ empathy declines during their training¹¹¹⁻¹²⁰. To develop more insight into the Dutch situation, future research into Dutch medical students’ views on aspects of empathy seems called for, for instance using in-depth interviews. Additionally, it would be instructive to measure empathy in GP-residents during patient-GP consultations in their first year of vocational GP education and at the end of the third year. Moreover, to better understand the possible decline in empathy and to ensure that tomorrow’s GPs are empathetic as well as competent, it would be instructive to analyze the opinions of GP-residents throughout the residency program about empathy and the importance of empathy. Within this framework attention should be paid to a research design with residents in a hospital setting which will be soon performed.

Since there is no conclusive evidence as yet that participating in courses such as mindfulness courses and meditation courses actually helps GPs to find out what degree of empathy suits them best, how to cope with professional and private stress, and whether gender differences play a part further research within this framework is necessary^{76,121-123}.

Besides, regarding the important role of the reception staff, professional associations of practice assistants should emphasize the need for research into the presence of programs in vocational training that support reflection on personal emotions, coaching and stress reduction of practice assistants.

Implications for practice

The findings of this study lead to a number of implications for daily general practice. If we want to support empathic GPs who are connected to the patient in a continuing cycle of reflexive interpretation, then paying more attention to the development of the GP as an authentic person is important. Moreover, tending to their emotional and psychological balance and wellbeing by creating the right practical conditions should become a priority. Providing the necessary tools and resources such as continuous education and intervision which include coaching and supporting courses should also be a high priority.

GPs and general practice stakeholders should be aware of the position of the reception staff. They can only be expected to provide trust and openness for patients, whether on the telephone or in person, when they are well-trained professionals who feel secure in their setting. Practice staff members can only respond adequately and empathically to distressed individuals and develop trustful relationships with fellow human beings, when they feel that they are being heard at an emotional level by GPs in their own practice organization. Empathy can play an important part in achieving a meaningful and effective practice organization, in that it helps in fostering personal connections and supporting and integrating teams of people^{54,124-126}.

If we want to promote best practices in general practice care it is essential to support and to insist on paying attention to the way GPs search for a practical form of person-centered care. In order to implement our findings into practice it is important that health insurance organizations and policy makers realize that empathy can only occur successfully when it is valued as an important aspect of patient-GP communication and when there is enough emotional and cognitive space for it in daily general practice.

Implications for education and training

During Dutch vocational training, communication skills and medical knowledge are both dealt with extensively¹²⁷⁻¹³¹. First year GP trainees reported mainly problems with communication skills¹³². Evaluation of the opinions of Dutch GP-residents shows that many of them feel that

too much attention is being paid to “patient-GP communication”¹³³. However trainees’ communication skills are at an unsatisfactory level at the end of training^{129,134,135}.

It seems that the development of communication skills throughout the GP training, shows a similar pattern as the afore-mentioned decline in empathy in American medical students during their study. As both patients and GPs in this study and primary care teachers¹⁸ as well highlight the value of empathy in patient-GP communication, attention should be paid during medical and GP education to specific empathy-enhancing components. For example to adapt family medicine curricula by introducing specific courses, training and interventions that promote the use of empathy. Or, more contact with patients and introducing humanities^{19,30,33,117,121,122,136-142}. Another suggestion is based on neuroscientific insights. These insights suggest that it is possible to enhance empathy by strengthening the neural networks that facilitate its expression through teaching, explicating and experiential training^{143,144}. Furthermore, transferring theoretical knowledge about the neuroscience of empathy during GP training showed improved empathy towards others as well as a positive attitude to empathy¹⁴³⁻¹⁴⁷.

In GP education in the Netherlands the shortcoming regarding communication skills has been noticed and suggestions have been made to improve the situation^{128,135,138,148,149}. One of them, the so-called ‘communication wheel’, was recently introduced, as a result of a report of the study group called APC (*Arts-Patiënt Communicatie*, i.e. Physician-patient Communication). This tool was developed to assess trainees’ advancements in patient-GP communication. However, since empathy is not explicitly tested in this ‘communication wheel’ but only as an implicit part of basic consultancy skills, this assessment tool requires some fine-tuning^{150,151}.

It is still unknown in which phase of medical education (medical school, GP residency or post-academic training) it is the most appropriate to address empathy. It could be argued that it is beneficial to start empathy-education during the basic years, so that students have as much opportunity as possible to get to know their own talents, shortcomings and preferences. Furthermore, it should be noted that it is important to pay attention, during medical education, to a doctor’s personal development¹⁴⁸. The cultivation and formation of personality traits and professional identity should play a central role in this person-oriented approach^{123,152}. In American universities, this approach is implemented by, among other things, courses in which literature, cinema and poetry are used¹⁵²⁻¹⁵⁵.

In post-academic training it is already recognized that supervision is an indispensable attribute in developing an authentic role as a GP. It seems only natural that this supervision is followed up by organized intervision for practising GPs, organized by CME-organizations. The Dutch General Practitioners Society already organizes intervision (intercollegial counseling) courses; this initiative deserves promotion and imitation.

Final remarks

This thesis underlines the effectiveness of and the great value that patients and GPs attribute to empathy within patient-GP communication. Both patients and GPs worry about the vulnerable position of empathy in the current task-oriented view of patient-GP communication and in the way in which general practice is practically organized nowadays.

Empathy should be a key part of the medical encounter. More insight is needed into how the position of empathy can be optimized, how empathy can be explicitly established in communication between patients and GPs and their practices, and how GPs can be supported in preserving empathy as an important characteristic of person-centered care. The suggestions in this thesis can help to broaden the insight of GPs, GP-organizations and GP-education and can stimulate a debate on how the overall position of empathy can be guaranteed in the long term.

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9

Summary
Samenvatting
Dankwoord
Curriculum Vitae



“Empathy should not be limited to the consulting room; it should be part of the philosophy of the entire practice, of everyone who works in the practice.”

(a GP)

This qualitative methods thesis describes patients' and GPs' experiences with and opinions about empathy in patient-GP communication. The aims of the study are:

- To describe the existing knowledge from scientific studies investigating the proven effectiveness of empathy in general practice.
- To specify and to compare the expectations and opinions of patients and GPs with regard to empathy in patient-GP communication.

Pertaining only to patients:

- To describe patients' experiences with and opinions about empathy during consultations in primary care, and how they value it.

Pertaining only to General Practitioners:

- To describe GPs' experiences with and opinions about empathy and to explore obstructing and facilitating factors in the implementation of empathy in daily general practice.

Chapter 2 presents an introduction to the main concept of this dissertation. It discusses the background of empathy in patient-GP communication and presents the aims of the study. Firstly the chapter throws light on the general concept of empathy and on some aspects that empathy entails; subsequently how it is defined in medical literature. Moreover, neural and physiological perspectives on empathy are discussed. This chapter clarifies how the present disease-centered approach and organization of primary care can lead to a growing dichotomy between a biomedical and a humane basis of general practice and how this could influence patient-GP communication. Changes in patients' expectations are also discussed. Finally, the introductory chapter identifies how knowledge about patient-GP communication has evolved in the research field. Furthermore, it describes the gap in knowledge about the position and function of empathy within daily patient-GP communication.

Chapter 3 contains a review of literature studying the effectiveness of empathy in GP practice. This review focuses on empirical research published in the past 15 years. The review identifies six aspects that seem to be related to empathy. The included articles identify a correlation between GP empathy and patient satisfaction and a positive relationship between GP empathy and stronger patient enablement. They show that a GP's empathic behaviour results in a reduction in patients' anxiety and distress. With regard to clinical outcomes there seems to be a relationship between empathic GPs (measured by the JSPE measure) and significantly lower HbA1c and LDL-cholesterol test results with diabetic patients; common cold symptoms seem to be less severe and long-lasting as the result of GPs' empathic behaviour. Furthermore, patients whose GPs have a positive attitude towards expressing concern and empathy, offer relatively more information about psychological and

social issues.

The review demonstrates that there is a connection between GP empathy and patients' physical and psychosocial health outcomes.

Chapter 4 concentrates on how patients experience empathy in the clinical encounter in primary care and what opinions they have about the position of empathy. This was researched in a qualitative study based on an in-depth focus group interview method. Adult participants who had visited their GP at least once in the previous year were recruited from the general population by means of a press briefing in free public local newspapers. People who had been involved in a formal complaint procedure with a GP were excluded. The study shows clearly that participants are very aware of the impact of empathy in the primary care encounter. Almost all participants state that when a GP shows empathy, it results in satisfying consultations. Furthermore, a GP's empathic behaviour enhances their coping behaviour and leads to a sense of enablement. An experienced lack of empathy is identified as resulting in stressful consultations in which participants feel disappointed, upset and overwhelmed. There is evidence that in the long term a lack of empathy can lead to patients avoiding contact with their GP or even switching to another GP. Some participants state that a lack of empathy can be an obstacle to receiving adequate primary care. Interestingly, some participants show a willingness to forgive GPs for their shortcomings in showing empathy, mentioning time pressures, red tape or simply not getting along on a personal level as potential reasons. Participants also mention potential negative side effects of a GP showing empathy. They describe how empathy can make them divulge too much private information, or how a GP's empathic approach can make them anxious about their condition. Some participants mention their concerns about the negative effects that GPs might experience as a result of being empathetic.

In order to identify GPs' experiences and views, in-depth interviews with GPs were conducted. The results of these interviews are described in **chapters 5 and 6**. Using a systematic random sampling procedure, participants were recruited from the NIVEL (Netherlands Institute for Health services research) GP-registrar. Thirty in-depth interviews were performed with a heterogeneous sample of Dutch GPs (heterogeneous in gender, age, type of practice and rural or urban setting) and analysed according to the constant comparative analysis method.

Chapter 5 focuses on how GPs assess and accomplish empathy. The participating GPs regard empathy as an important element of the consultation. They generally assess empathy as an opportunity to recognize patients as equal human beings. According to the GPs, being

genuine and respectful, cultivating a good atmosphere and showing feelings of equality are prerequisites for empathic behaviour.

They consider non-verbal aspects of empathic communication (e.g. having an interested facial expression, keeping eye contact and using actively interested body language) to be essential. In addition, GPs describe verbal aspects such as being alert to cues and reacting to them, and referring to previous consults or life events.

In the interviews GPs stress that physical fitness, not being distracted by private worries or by practice assistants or telephone calls, the absence of time-pressure, and an efficient practice organization are important preconditions for being empathic. Furthermore, GPs stress the importance of having the opportunity to reflect on their work in organized intervision or Balint groups. Furthermore, they suggest that longer consultation times, efficient telephonic triage by practice assistants and smaller practices can be helpful in facilitating empathy. Generally, the GPs regard empathy as a positive factor that contributes to job satisfaction.

Chapter 6 explores in more detail what barriers GPs encounter in applying empathy and how they manage these barriers. Protocol-driven care, with its guidelines, obligatory questioning and bureaucratic requirements, is mentioned as an important potential barrier for GPs to remain genuinely person-oriented during the consultation. GPs indicate that they sometimes deviate from the recommendations given in the guidelines in order to preserve a patient-as-person approach. GPs underline that the tension between being emotionally involved and keeping a professional distance can be a barrier.

Since both patients and GPs indicated that their wishes to receive and to provide empathy are not always fulfilled, **Chapter 7** explores the differences in the expectations and experiences of both groups, using a comparative qualitative analysis. This part of the study is based on data from five focus group discussions with a total of 28 participants, and from thirty interviews with GPs. We identified several circumstances that make it difficult or impossible to fulfil patients' and GPs' expectations. Circumstances that patients identify as hampering empathy are: not having sufficient consultation time, a GP not showing enough authentic interest and concern, a lack of eye contact during the consultation, a GP being distracted by organizational or personal issues and unwelcoming behaviour by reception staff. All these circumstances stand in the way of the patient's expectations of being given room to speak freely, of creating common ground and of being involved in making decisions. Both GPs and patients indicate that there needs to be some kind of personal bond or connectedness for an empathic patient-GP relationship to grow. GPs express that feeling tired or going through private problems can make them act less empathically than they would

want. In addition, they indicate that there is a limit to how much empathy they can offer during the patient-GP encounter.

In **Chapter 8** the results of this dissertation are discussed. In this section the three levels of empathy (i.e. attitude (affective), competency (cognitive), and behaviour) are connected to GPs' and patients' experiences and opinions as found in this study. Four themes, arising from the results of the thesis, are explored in detail, namely: (1) conflicting perspectives on telephonic triage; (2) the pronounced effect of empathy on feelings of safety, trust and support; (3) the impact of clinical guidelines and protocols; and (4) the balance between emotional involvement and professional distance.

Firstly, the conflicting perspectives on telephonic triage with regard to delivering and experiencing empathy. Our study shows that patients often experience this triage by practice assistants as an obstacle to getting access to the GP; it gives them a sense of being treated with a lack of empathy and respect. GPs on the other hand regard telephonic triage to be a necessary instrument in providing care. These conflicting points of view raise the question whether the current triage system is appropriate.

Secondly, the pronounced effect of empathy on patients' feelings of safety, trust and support. Patients strongly appreciate these feelings and associate them with being assisted in developing adequate coping strategies to take control of their own situation. According to patients and theorists, empathy seems to be embedded in concepts such as trust and enablement.

The third and fourth themes are related specifically to GPs' perspectives on empathy. The third is the impact of clinical guidelines and protocols on GPs' empathic behaviour. GPs in this study show concern about the increasingly important role of guidelines and protocols in primary care; many of them regard questioning protocols and guidelines as 'straitjackets'. They feel that, in order to deliver high quality personalized care, it is necessary to be flexible and to deviate from the recommendations described in the guidelines when called for. The fourth theme that is discussed is the difficulties that GPs can face in balancing emotional involvement and professional distance. Caring can be stressful, difficult and emotionally draining and concern for others can sometimes stand in the way of caregivers taking care of themselves. GPs in this study indicate that there are limits to their ability to cope with the combination of daily practice and private life. As an addition to this theme, the connection between empathy and burnout is discussed; interestingly, empathy can both contribute to developing burnout and to protecting against it.

Finally, chapter 8 discusses the implications from this thesis for research, practice and education and training. More mixed-method research is needed to draw attention of GPs and GP-organizations to the position and function of empathy in daily practice. Furthermore, the

views of health insurance companies on the barriers GPs experience should be explored, as should the views of health insurance companies on pay for performance (e.g. "kijk en luistergeld"). More research is needed into how medical students and GP-residents view the position and function of empathy in their clinical work. Professional associations of practice assistants should emphasize the need for research into programmes in vocational training that support and stimulate reflection on personal emotions, coaching and stress reduction of practice assistants.

This thesis suggests that organizing continuous education and intervision should be a high priority in order to improve empathy in daily clinical practice. GPs in their turn can play an important part in supporting the reception staff in using empathy.

Specific courses and training for medical students and GP residents should be introduced to promote the use of empathy. Including literature (novels and poetry) and cinema in these courses might be a helpful instrument. As a final recommendation it is mentioned that, to assess trainees' advancements in patient-GP communication, especially in their empathic behaviour, there should be further fine-tuning of the assessment tool (i.e. the communication wheel).

Dit proefschrift is gebaseerd op kwalitatief onderzoek en beschrijft de ervaringen en meningen van patiënten en huisartsen met betrekking tot empathie in de communicatie. De studie heeft de volgende bedoelingen:

- De bestaande kennis beschrijven van wetenschappelijke studies waarin onderzoek is gedaan naar bewezen effectiviteit van empathie in de huisartspraktijk.
- Het beschrijven en vergelijken van de verschillende verwachtingen van patiënten en huisartsen ten aanzien van empathie in hun communicatie.

Met betrekking tot patiënten:

- Het beschrijven van de ervaringen, de meningen en de waardering van patiënten ten aanzien van empathie tijdens een consult.

Met betrekking tot huisartsen:

- Het beschrijven van de ervaringen en meningen van huisartsen over empathie en onderzoeken welke factoren belemmerend of juist bevorderend werken in de dagelijkse praktijk.

Hoofdstuk 2 introduceert het thema van dit proefschrift. De achtergronden van empathie in de communicatie tussen patiënt en huisarts worden gepresenteerd evenals de bedoelingen van de studie. Het concept empathie wordt in dit hoofdstuk besproken evenals een aantal aspecten van empathie; ook de definitie, zoals die besproken wordt in de medische literatuur, komt aan de orde. Tevens worden neurowetenschappelijke en fysiologische aspecten van empathie behandeld. In dit hoofdstuk laten we zien waarom de huidige, op ziektes georiënteerde benadering, en de huidige organisatie van de eerstelijnszorg kunnen leiden tot een groeiende tweedeling tussen de biomedische en de menselijke basis van de huisartsenzorg, evenals die van de communicatie tussen patiënt en huisarts. Ook de veranderde verwachtingen van patiënten worden besproken. Tenslotte wordt in deze introductie beschreven hoe de kennis over de communicatie tussen patiënt en huisarts zich ontwikkeld heeft en welk kennistekort nog bestaat over de positie en functie van empathie in de dagelijkse communicatie tussen patiënt en huisarts.

Hoofdstuk 3 bevat een literatuurstudie betreffende de effectiviteit van empathie in de huisartspraktijk. Het concentreert zich op gepubliceerd wetenschappelijk onderzoek van de laatste 15 jaar. Er worden 6 aspecten benoemd waarbij een relatie met empathie lijkt te bestaan. Uit de geselecteerde artikelen blijkt dat er zowel een relatie lijkt te bestaan tussen empathisch gedrag van de huisarts en tevredenheid van de patiënt als een versterking van het eigen oplosgedrag van de patiënt. Ze laten zien dat empathisch gedrag van de huisarts resulteert in minder angst en spanning bij de patiënt. Met betrekking tot klinische waarden lijkt er een relatie te bestaan tussen empathisch gedrag van de huisarts (gemeten met

behulp van de JSPE-methode) en significant lagere waarden van het HbA1c en LDL-cholesterol bij suikerpatiënten; gewone verkoudheidsverschijnselen lijken ook minder ernstig te zijn en minder lang te duren als gevolg van empathisch gedrag van de huisarts. Als huisartsen betrokkenheid en empathie uitstralen, geven patiënten meer informatie over psychologische en sociaal-maatschappelijke aspecten van hun situatie.

De literatuurstudie laat zien dat er een relatie lijkt te bestaan tussen empathie van de huisarts en fysieke zowel als psychosociale kenmerken van de gezondheid van de patiënt.

Hoofdstuk 4 concentreert zich op hoe patiënten empathie ervaren en welke meningen zij over de positie van empathie hebben. De basis van dit deel van het kwalitatieve onderzoek wordt gevormd door het uitvoeren van focusgroep-interviews met patiënten. Deelnemers werden geselecteerd uit de algemene populatie met behulp van persberichten in verschillende huis-aan-huisbladen. Deelnemers mochten mee doen als ze volwassen waren en het laatste jaar minstens eenmaal hun huisarts hadden bezocht. Uitgesloten van deelname waren mensen die in een klachtenprocedure met hun huisarts waren verwikkeld. De studie toont duidelijk aan dat de deelnemers zich erg bewust zijn van de invloed van empathie in het consult met hun huisarts. Bijna allemaal benadrukken ze tevreden te zijn over het consult als de huisarts empathisch gedrag vertoont. Bovendien versterkt dit hun eigen oplosgedrag. Als ze geen empathie ervaren, resulteert dat in gestreste consulten; patiënten voelen zich teleurgesteld en raken in de war. Op langere termijn gaan ze door de afwezigheid van empathie een bezoek aan de huisarts mijden of ze veranderen daardoor zelfs van huisarts. Sommigen concluderen dat ze door een gemis aan empathie geen adequate eerstelijnszorg ontvangen. Interessant genoeg geeft een aantal deelnemers aan wel begrip te hebben voor de tekortkomingen op dit vlak van de huisarts. Zij noemen tijdgebrek, administratieve rompslomp en het simpelweg niet met elkaar kunnen vinden, als mogelijke oorzaken van het tekort aan empathie. Ook benoemen ze mogelijke nadelen van empathisch gedrag van de huisarts. Empathie zou hun kunnen verleiden om te veel privé-informatie te verschaffen en sommigen worden door empathisch gedrag van de huisarts juist bezorgd over hun situatie. Sommige deelnemers tonen zich ook bezorgd over mogelijke negatieve effecten van empathie op de huisarts zelf.

Om de ervaringen en meningen van huisartsen vast te stellen, zijn huisartsen geïnterviewd. De resultaten daarvan worden in **hoofdstuk 5 en 6** beschreven. De deelnemers werden geselecteerd met behulp van een steekproef uit het huisartsenbestand van het NIVEL (Nederlands Instituut voor de Eerste Lijn). Een heterogene steekproef (qua geslacht, leeftijd, soort praktijk en stad of platteland) werd gemaakt. Dertig interviews zijn uitgevoerd.

Hoofdstuk 5 staat stil bij hoe huisartsen empathie waarderen en uitvoeren. Vrijwel alle deelnemende huisartsen beschouwen het als een belangrijk element in het consult. Zij zien het als een mogelijkheid om patiënten menselijk en gelijkwaardig te benaderen. Als voorwaarden voor empathisch gedrag vinden huisartsen dat ze authentiek moeten zijn, met respect de patiënt moeten benaderen, een goede atmosfeer moeten creëren en op voet van gelijkheid dienen te communiceren.

Ze beschouwen non-verbale communicatie (geïnteresseerde gezichtsuitdrukking, direct oogcontact, een actieve luisterhouding) essentieel. Tevens onderschrijven ze het belang van verbale aspecten zoals het alert reageren op 'cues' tijdens het consult en terugkomen op eerdere contacten of gebeurtenissen.

Zich fit voelen, niet afgeleid worden door privéomstandigheden of door inkomende telefoontjes, geen tijdsdruk ervaren en een efficiënte praktijkorganisatie worden beschouwd als belangrijke voorwaarden om empathisch te kunnen zijn. Verder vinden huisartsen het belangrijk om de mogelijkheid te hebben om te reflecteren op hun werk (door middel van georganiseerde intervisie, Balint-groepen). Ook langere consulten, kleinere praktijken en efficiënte triage aan de telefoon kunnen helpen. Algemeen gesproken vinden huisartsen dat empathie het plezier in hun werk versterkt.

Hoofdstuk 6 gaat meer gedetailleerd in op de obstakels die huisartsen tegenkomen bij het toepassen van empathie en hoe ze daar mee omgaan. Standaarden, met hun verplichte vraagstellingen en administratieve handelingen, worden gezien als een belangrijke drempel om authentiek en persoonlijk te blijven tijdens het consult. Huisartsen geven aan dat zij daarom soms bewust afwijken van de aanbevelingen van de standaard. Een andere drempel die huisartsen benoemen is de spanning die ze ervaren tussen emotionele betrokkenheid en professionele afstand.

Omdat zowel patiënten als huisartsen aangaven dat hun wensen om empathie te ontvangen of te geven niet altijd vervuld worden, onderzoekt **hoofdstuk 7** de verschillen tussen verwachtingen en ervaringen. Daarbij is gebruik gemaakt van een comparatieve kwalitatieve analyse. Dit onderzoeksdeel is gebaseerd op de resultaten uit 5 focusgroepen (totaal 28 deelnemers) en uit 30 interviews met huisartsen. Hieruit blijkt dat verschillende omstandigheden het bevredigen van de verwachtingen van patiënten en huisartsen bemoeilijken. Patiënten noemen onder meer: te weinig tijd tijdens het consult, een niet geïnteresseerde en weinig betrokken huisarts, geen direct oogcontact tussen patiënt en huisarts, een huisarts die afgeleid wordt door organisatorische of persoonlijke zaken en afwijzend gedrag van de praktijkassistenten. Deze omstandigheden verhinderen dat verwachtingen van patiënten uitkomen om bijvoorbeeld vrijuit te kunnen praten en betrokken

te worden bij het nemen van beslissingen. Zowel patiënten als huisartsen vinden dat een persoonlijke band nodig is om een empathische relatie op te bouwen. Huisartsen noemen verschillende omstandigheden die in de weg kunnen staan van wat zij aan empathie verwachten te kunnen geven, zoals zich niet fit voelen, afgeleid zijn door privé zaken en doordat er simpelweg een grens is aan wat ze aan empathie kunnen bieden.

Hoofdstuk 8 bespreekt de resultaten van deze dissertatie. In dit deel worden de 3 niveaus van empathie (houding (affectief), vaardigheid (cognitief) en gedrag) in verband gebracht met de ervaringen en opinies van patiënten en huisartsen. Vier thema's zoals die uit de resultaten van dit onderzoek naar voren zijn gekomen, worden diepgaander behandeld, namelijk: (1) tegenstrijdige perspectieven ten aanzien van telefonische triage; (2) het opvallende effect van empathie op gevoelens van veiligheid, vertrouwen en steun; (3) de invloed van standaarden en protocollen; (4) de balans tussen emotionele betrokkenheid en professionele afstand.

Het gaat dan in de eerste plaats om de tegenstrijdigheid tussen enerzijds de meningen van de patiënten en anderzijds van de huisartsen over de telefonische triage door de assistentes. De studie laat zien dat patiënten de triage door assistentes vaak als een belemmering zien om contact te krijgen met de huisarts; ze ervaren daardoor minder empathie en respect. Huisartsen vinden die triage juist een belangrijk instrument om de meest nuttige zorg te verlenen. Dit verschil van mening doet de vraag rijzen of het huidige triagesysteem wel voldoet.

Een tweede punt dat patiënten in deze studie naar voren brengen is dat empathisch gedrag van de huisarts voor hen duidelijk effect heeft op zich veilig en gesteund voelen en op vertrouwen hebben. Zij stellen deze gevoelens erg op prijs en voelen zich daardoor ondersteund in het ontwikkelen van adequaat oplosgedrag voor hun eigen situatie. Het lijkt erop dat zowel patiënten als theoretici empathie in de spreekkamer zien als iets wat inherent is aan concepten als vertrouwen en *enablement* (het versterken van eigen oplosgedrag). Het derde en vierde thema zijn specifiek gerelateerd aan de perspectieven van huisartsen op empathie. Het derde betreft de invloed van standaarden en protocollen op het empathische gedrag van de huisarts. De huisartsen in deze studie zijn bezorgd over de toenemende invloed van de standaarden op de eerstelijnszorg; het geprogrammeerd vragen stellen ervaren ze als een keurslijf. Om hoog gekwalificeerde persoonlijke zorg te kunnen leveren is het nodig om flexibel te zijn en waar nodig bewust af te wijken van de aanbevelingen uit de standaarden.

In dit hoofdstuk wordt als vierde thema besproken dat het moeilijk kan zijn voor huisartsen om een balans te vinden tussen emotionele betrokkenheid en professionele afstand. Zorgen voor mensen kan stress opleveren en emotioneel belastend zijn. Betrokkenheid bij andere

mensen kan soms de zorg van zorgverleners voor zichzelf hinderen. In deze studie geven huisartsen aan dat er grenzen zijn aan het kunnen combineren van de zaken uit de dagelijkse praktijk en die uit hun privéleven. In dat kader wordt ook de relatie tussen empathie en burnout besproken. Opvallend genoeg blijkt dat empathie zowel een oorzaak van als een bescherming tegen burnout kan zijn.

Tenslotte bespreekt hoofdstuk 8 de consequenties van de resultaten van dit onderzoek voor verder onderzoek, voor de dagelijkse praktijk en voor het onderwijs. Er is meer onderzoek nodig met gemengde methodes, om de aandacht van huisartsen en huisartsenorganisaties te wekken voor de positie en functie van empathie in de dagelijkse praktijk. Ook adviseren we dat onderzoek gedaan moet worden naar de opinies van de zorgverzekeraars; het gaat dan vooral om hun visie op de obstakels die huisartsen ervaren en op het idee van 'kijk en luistergeld'. Ook is het belangrijk onderzoek te doen naar de meningen van medische studenten en huisartsen in opleiding over de verschillende aspecten van empathie en over hun ideeën over de positie en functie van hun empathische gedrag. De beroepsorganisatie van praktijkassistenten zouden onderzoek moeten doen naar het opzetten/toetsen van programma's tijdens de opleiding die reflectie op persoonlijke emoties, coachen en stressvermindering ondersteunen en stimuleren.

Dit proefschrift suggereert dat, om empathie in de dagelijkse praktijk te verbeteren, een georganiseerde en continue vorm van educatie en intervisie hoge prioriteit moet hebben. Huisartsen zelf spelen een belangrijke rol in het ondersteunen van het toepassen van empathie door hun assistentes.

Specifieke cursussen en trainingen voor medische studenten en huisartsen in opleiding zouden moeten worden geïntroduceerd die het gebruik van empathie stimuleren. Het bespreken van literatuur (boeken en poëzie) en films kan hier behulpzaam bij zijn. Een laatste aanbeveling is om de vorderingen in het empathisch gedrag van huisartsen in opleiding te toetsen met een aangepaste versie van het communicatiewiel.

Dankwoord

Ongeveer tien jaar geleden begon mijn project 'empathie' in een van de gangen van het Slingeland ziekenhuis in Doetinchem. Een chirurg sprak mij aan en maakte mij duidelijk dat hij vond dat de herinnering aan de klassieke (traditionele) manier van 'huisarts zijn' bewaard moest worden voor de jongere generatie huisartsen. Hiermee stimuleerde hij mij, ik denk onbewust, om de casuïstiek die in mijn laptop sluimerde wakker te maken; er ontwikkelde zich een plan een boek te schrijven dat zou werken als een inktijk in een huisartsenkeuken, mijn keuken. Als rode draad koos ik voor de positie en het functioneren van empathie in de communicatie tussen patiënt en huisarts. Als doelgroep heb ik toen huisartsen in opleiding gekozen. Jozien is indertijd bereid geweest om het boekje te beoordelen en was er enthousiast over. Hoewel ze mij verschillende keren heeft gewaarschuwd voor de omvang van een promotietraject wist zij mij ook te enthousiasmeren voor wetenschappelijk onderzoek aangaande empathie in de communicatie tussen patiënt en huisarts. Voor De en mij was het een reden te meer om, vóór ons vijftenzestigste, te stoppen met het huisartsenwerk en de praktijk voortijdig over te doen aan een opvolgster.

Omdat het onderzoek een huisartsgeneeskundig onderwerp betrof, heb ik, in overleg met Jozien, direct bij het begin van het onderzoek Toine gevraagd om mijn medepromotor te worden. Zij reageerde enthousiast en gedreven. Na een paar jaar werd Tim gevraagd om mijn copromotor te worden. Ook hij vond het fantastisch om aan dit project mee te werken. Zo ontstond het onderzoeksteam dat het project 'empathie' in de laatste jaren is gaan begeleiden.

Het uitvoeren van wetenschappelijk onderzoek en het op een onderwerp promoveren blijken inderdaad een zoektocht te zijn met vele dimensies. Vooraf kun je veel uitstippelen en een deel van de tocht kan volgens plan verlopen (bijv. artikelen die voor plaatsing worden geaccepteerd). Kenmerkend voor een zoektocht is echter ook dat je onderweg struikelblokken tegenkomt die vertragend en frustrerend werken, zoals onaangename reviews of het moeizaam kunnen vinden van deelnemers voor het onderzoek. Gelukkig heb ik de zoektocht niet alleen hoeven ondernemen; ik ben me bewust van het feit dat er onderweg verschillende mensen zijn geweest die zowel de positieve en negatieve momenten als de praktische en theoretische aspecten van de expeditie met mij hebben mee beleefd en mij hebben gesteund. Dit is de gelegenheid om die mensen te bedanken. Er is een aanzienlijke kans dat ik iemand zal vergeten; sorry daarvoor.

De hoekstenen van het project zijn de ervaringen en meningen van patiënten en huisartsen; deze ervaringen en meningen verankeren het onderzoek in de dagelijkse huisartspraktijk. Dit onderzoek en het schrijven van dit proefschrift hadden niet tot stand kunnen komen zonder de medewerking van patiënten en huisartsen.

Ik wil de dertig deelnemende huisartsen bedanken voor het vertrouwen en de openheid waarmee ze mij een inkijk gunden in hun praktische ervaringen; tevens ben ik dankbaar voor het feit dat ze hun persoonlijke motivaties met mij wilden delen. Allen waren gemotiveerd om over het onderwerp te worden geïnterviewd en offerden belangeloos minstens een uur van hun tijd op. De en ik hebben in een halfjaar, met veel plezier, Nederland van Groningen via Maastricht tot Vlissingen doorkruist; zij als chauffeur en ik ernaast het interview voorbereidend. Het was steeds verrassend hoe de huisartspraktijk eruit zou zien en hoe ik ontvangen zou worden.

Verder gaat mijn bijzondere dank uit naar de patiënten die deelgenomen hebben aan de focusgroepen. Hun verhalen bevatten niet alleen relevante informatie maar getuigden vooral van doorleefde ervaringen. Voor mij is het een buitengewone en onvergetelijke ervaring geweest om bij alle focusgroepen aanwezig te zijn, de verschillende belevenissen aan te horen en de onderlinge reacties op elkaars wedervaren te zien en te horen. Deze ervaring is van groot belang geweest om mijn motivatie voor het onderzoek te behouden en om me duidelijk te maken dat het belang van de patiënt een van mijn centrale beweegredenen voor dit onderzoek is geweest.

En dan natuurlijk mijn begeleidingsteam tijdens de tocht: prof. dr. Toine Lagro-Janssen, prof. dr. Jozien Bensing en dr. Tim olde Hartman. Eerst vergaderden we vooral telefonisch; in de laatste 2 jaren maandelijks in levenden lijve op de kamer van Toine. De sfeer van de bijeenkomsten was heel vertrouwelijk, ieder voelde zich op zijn gemak, er was belangstelling voor elkaars privésituatie, iedereen kon inbrengen wat hij of zij maar wilde en het geheel werd standaard begeleid met koek of chocola bij de thee. Het was echter geen 'theekransje'; er werd heftig gediscussieerd, er waren regelmatig duidelijke meningsverschillen, ieder bracht de eigen expertise over het consult tussen patiënt en huisarts en de eigen mening over de huidige en toekomstige organisatie van de huisartsenzorg in. Kortom, er gebeurde wat!! Terugkijkend hebben deze bijeenkomsten, zeker die van het laatste jaar, als katalysator voor mijn eigen beeldvorming rondom het onderwerp en als inspiratiebron voor de realisatie van artikelen gewerkt.

Beste Toine, wij kenden elkaar al van de tijd dat we samen in de collegebanken zaten aan

het begin van onze studie geneeskunde(1966-1967). Toen we beiden net huisarts waren, kwamen we elkaar opnieuw tegen in het kader van het organiseren van de nascholing voor huisartsen in de regio Nijmegen. Onze gemeenschappelijke historie leverde een vertrouwensband op die, in ieder geval voor mij, promoveren een stuk gemakkelijker gemaakt heeft. Op basis van je vriendschap (want zo heb ik dat wel gevoeld) bestonden er geen stomme vragen en kon ik altijd bij je aankloppen. Los daarvan kan niemand zich een aardigere, snellere (antwoordmails kwamen meestal per ommegaande), uitdagendere en meer geïnspireerde en betrokken promotor wensen. Veel dank voor je bezielende begeleiding.

Beste Jozien, jij bent in eerste instantie de initiator van mijn onderzoek geweest en hebt me in de loop der jaren het vertrouwen gegeven dat het onderzoek en een promotie zouden gaan lukken. Je opmerkingen waren voor mij heel ondersteunend, opmerkingen zoals: "Ik heb er vertrouwen in" of "Het gaat lukken" of "Het wordt heel mooi". Ik heb veel bewondering voor jouw deskundigheid en onderzoekservaring op het gebied van communicatie in de zorg – waarbij je bij voorkeur het patiëntenbelang probeert te behartigen - en vanwege de plek die je al jarenlang inneemt in organisaties die zich bezighouden met het Nederlandse zorgstelsel. Je artikelen en opmerkingen hebben me enorm geholpen om op een beschouwende en cognitieve manier naar empathie te kijken. Tijdens de bijeenkomsten, met 3 huisartsen aan tafel, bepleitte je steeds het belang van de patiënten in de zorg (dus ook in ons onderzoek) en de zuiverheid van kwalitatief onderzoek.

Echter, je constructieve feedback, je gedegen suggesties en visies zijn onmisbaar geweest; ik leerde er veel van, dank daarvoor.

Beste Tim, wat een 'boost' bracht jij binnen tijdens de laatste jaren van het project. Je structurerende hulp bij de analyse van de onderzoeksdata en bij de opbouw van de artikelen was onontbeerlijk. Zonder jou was het mij niet gelukt om dit project tot een goed einde te brengen. Verbaasd was ik steeds over je snelheid van reageren op mijn mails. Ik voelde me soms bezwaard, als ik dacht aan je patiënten. Ik heb er enorme bewondering voor dat jij, ondanks je drukke huisartspraktijk, toch op zo'n kernachtige en doortimmerde manier op mijn analyses en concepten reageerde. Ik waardeer je handigheid en kunde in het schrijven van artikelen. Bovendien wist je, met je opmerkingen zoals: "Wat bedoel je precies" of "Leg eens uit", mij te dwingen helder te formuleren wat ik precies bedoelde of wat ik nou precies wilde onderzoeken en me duidelijk te maken op welke manier ik met de data diende om te gaan. Ik vond het geweldig om met je samen te werken; als huisarts en als onderzoeker bracht je een grondige en coherente expertise in. Hoewel we zowel in leeftijd als in praktijkjaren vele jaren

schelen, vind ik het inspirerend en vertrouwenwekkend om te zien dat wij als mensen en als (ex-)huisartsen bijna naadloos met elkaar overeenstemmen als het gaat over de uitgangswaarden van het huisartsenvak.

Dit proefschrift werd beoordeeld door de manuscriptcommissie bestaande uit prof. dr. Judith Prins, prof. dr. Hanneke de Haes en prof. dr. Patrick Bindels. Allen betrokken vanuit verschillende invalshoeken bij het onderwerp en enthousiast om het proefschrift te lezen. Hartelijk dank voor jullie bereidheid om zitting te nemen in de commissie.

Als buitenpromovendus maakte ik niet echt deel uit van de onderzoeksgroep op de afdeling Eerstelijns geneeskunde. Toch voelde ik me altijd herkend door de verschillende medewerkers. Men was van mijn tocht op de hoogte. Secretariaresses en assistentes zoals Marike Jaegers, Nicola Lobo, Anouk Peters, Deborah van Leeuwen en Margreet Straver zijn me enorm behulpzaam geweest bij de praktische zaken rondom de huisartseninterviews en focusgroepen met patiënten. Vooral Twanny Jeysman ben ik dankbaar voor het uitwerken van zowel het manuscript als het proefschrift.

Ik heb weinig op het instituut ELG gewerkt; de keren dat ik er geweest ben, waren er echter hartelijke en intensieve contacten met de collegae promovendi van Toine. Heel graag bedank ik Maartje Loeffen, Elza Zijlstra en Kees de Kock voor hun belangstelling voor mijn onderzoek en voor hun positieve opmerkingen. Vooral de laatste jaren hebben Annette Plouvier en ik regelmatig met elkaar opgetrokken. Wederzijds hebben we geholpen bij elkaars onderzoek; Annette is coauteur van een van de artikelen geweest en we mailden regelmatig over werk en privé zaken. Hartelijk dank voor je hulp; ondanks ons leeftijdsverschil heb ik je ervaren als een soort 'maatje'.

Op mijn zoektocht hebben verschillende mensen als richtingaanwijzer geopereerd. Elmie Peters, bibliothecaresse van de Universiteitsbibliotheek, heeft mij de weg gewezen bij het verzamelen van onderzoekliteratuur rondom empathie. Zonder haar was het maken van een review niet gelukt. Gijs Hesselink heeft me, tijdens het patiëntendeel van het onderzoek, op een zinnige en instructieve manier geholpen bij het ontwikkelen van ideeën om deelnemers voor de focusgroepen te vinden. Peter Lucassen heeft met een aantal positieve en opbouwende opmerkingen de inhoud van de review op een hoger plan getild, dank daarvoor. Ook Hennie Boeije, werkzaam op het NIVEL, heeft ons bij het werken met de focusgroepen van heel nuttige informatie voorzien.

En dan zijn er een paar reizigers geweest die stukken van de tocht met me meegelopen zijn.

Om mijn interviewtechniek voor de interviews met de huisartsen onder de knie te krijgen heb ik met een aantal oud-collegae huisartsen proefinterviews gedaan. Dat waren achtereenvolgens: Otto Sechterberger, René de Planque, Alex Harftenkamp en Christine van der Pol. Hun reflecties zijn enorm nuttig voor me geweest.

Drie studentes hebben in het kader van hun wetenschappelijke stages mij geholpen bij de analyses van de onderzoeksdata: Sascha Kuiper, Milou van Meerendonk en Annelies van Dijk. Hartelijk dank voor jullie hulp.

Bij alle zeven focusgroepen met patiënten is Loes Veraart voorzitter/moderator geweest. Loes, om samen met jou letterlijk en figuurlijk op reis te zijn is een bijzondere ervaring geweest. Het samen naar Nijmegen rijden en de groep voorbespreken; en het nadien weer, al analyserend wat we meegemaakt hadden, terug naar huis rijden, waren intensieve en warme ervaringen. Het is je kracht om deelnemers in groepen, ook als er confronterende momenten zijn, zoveel mogelijk in hun waarde te laten, zonder dat zoiets gepaard gaat met een gemis aan diepgang.

Al mijn artikelen en ook dit proefschrift zijn in het Engels geschreven. Daar ben ik niet zo goed in. Maar gelukkig zijn er twee mensen geweest die als native speaker en als near-native speaker mij onderweg hebben bijgestaan: Rosamund Havard en Judith Tijman. Vooral Judith is de afgelopen jaren voor mij een formidabele steun geweest omdat ze de verschillende stukken las en zowel tekstueel als wat betreft het Engels corrigeerde. Dan waren er ook mensen buiten mijn directe 'werk' die zorgden voor de nodige steun op mijn reis en die steeds belangstellend waren naar de voortgang van het onderzoek. Vrienden hebben mij op verschillende manieren bij de les gehouden en ondersteund. Ze deden dat door het tonen van interesse in mijn werk maar ook door bewondering te laten blijken voor mijn doorzettingsvermogen om tijdens het gepensioneerd zijn een dergelijk project aan te pakken. Ook werd ik gepord door hun relativerende maar niet minder ondersteunende opmerkingen als: "Hoe staat het met je huiswerk?" of "Wanneer is er een feestje?". De nadruk op het belang van het onderzoek naar empathie die gelegd werd vanuit de verschillende clubs met 'pensionado's' en die van oud-collegae en zelfs van oud-patiënten was ondersteunend en hartverwarmend.

Ruim voor het begin van deze zoektocht, tijdens mijn jeugd, zijn het mijn ouders geweest van wie ik geleerd heb dat je de regie over je eigen leven moet houden; dat je onafhankelijk en eigenzinnig mag zijn. Pas nu beseft ik dat ze vertrouwen in mij hebben gehad en me daarom al vroeg durfden los te laten. Daar ben ik ze alsnog dankbaar voor.

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De, vele jaren zijn we bij elkaar en we hebben samen de 'toko' (huisartspraktijk) gerund. Ik ben me er van bewust dat mijn vele uren werk achter het scherm tijdens de afgelopen 6 jaar een belasting zijn geweest voor jouw geduld (als dingen weer eens mis gingen), onze "pensionado"-tijd (waarin we alleen maar leuke dingen zouden doen) en je uithoudingsvermogen. Ik weet dat ik de afgelopen jaren, door mijn ups en downs, vaak niet gezellig ben geweest en dat het voor jou soms ook afzien was. Door je onzelfzuchtigheid en door je besef dat het voor mij een belangrijk issue was heb ik kunnen doen wat ik wilde doen. Daarnaast wist je mijn werk en gedrevenheid soms flink te relativieren. Ik dank je voor je onvoorwaardelijke steun en altruïsme en beloof het de komende jaren beter te zullen doen.

CURRICULUM VITAE

Frans Derksen is geboren op 27 april 1947 in Arnhem. Hij was de oudste in een gezin met 3 zonen. Hij behaalde zijn MULO-B diploma in 1963 aan de Kardinaal de Jong MULO in Arnhem. In 1966 behaalde hij zijn HBS-B diploma aan het Thomas a Kempis College aldaar en aansluitend begon hij aan de studie geneeskunde aan de Katholieke Universiteit te Nijmegen. In november 1974 doorliep hij een maand de stage huisartsgeneeskunde (oude curriculum) in een klein dorp in de buurt van Doetinchem en bemerkte dat 'huisarts-zijn' zijn ding was. Na het behalen van zijn artsdiploma in januari 1975 startte hij direct als assistent in een groeiende huisartspraktijk in Doetinchem. Een jaar later werd hij daar associé; tot 2002 werkte hij in een duomaatschap en daarna nog 8 jaar als solist. Zijn interesse ging uit naar het samenwerken met andere disciplines in de eerstelijnszorg; dus hij organiseerde al snel 'hometeams'. Naast het werk als huisarts was vooral het organiseren van de nascholing voor huisartsen in de regio Oude IJssel zijn aandachtsgebied. Samen met een aantal collegae huisartsen heeft hij in het begin van de jaren 80 een structuur van 'sandwich' dagen voor de nascholing in de regio gevestigd. Een ander aandachtsgebied is het opleiden tot huisarts geweest; tot 2001 is hij betrokken geweest bij de huisartsopleiding van Nijmegen en heeft met meerdere aio's (huisartsen in opleiding) in zijn praktijk gewerkt. In begin 2003, gedwongen door een lichamelijk probleem, heeft hij een aantal maanden niet kunnen werken als huisarts en is daarna minder gaan werken. Nadat hij in 2009 het boekje over empathie schreef en de mogelijkheid tot het verrichten van wetenschappelijk onderzoek op zijn pad kwam is hij op 1 april 2010 gestopt met het 'huisarts-zijn' en in najaar van 2010 gestart met het promotieonderzoek naar empathie in de communicatie tussen patient en huisarts. Frans is getrouwd met Dore (al die jaren ook praktijkassistente geweest) en samen hebben ze twee kinderen, Karlijn (1975) en Floris (1979).

